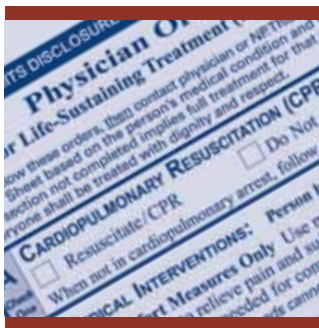


SPECIAL ARTICLE



The POLST Paradigm: Respecting the Wishes of Patients and Families

Patrick M. Dunn, MD, Susan W. Tolle, MD, Alvin H. Moss, MD,
and Judith S. Black, MD, MHA

INTRODUCTION

Despite the hope that traditional advance directives would ensure that patients' end-of-life treatment preferences are honored, numerous studies have found that only 20-30 percent of U.S. adults have an advance directive, and that these documents have limited effect on treatment decisions near the end of life.¹ Some of the limitations associated with traditional advance directives are that they may not be available when needed, are not transferred with the patient, may not be specific enough, may be overridden by a treating physician, and do not immediately translate into a physician order.

The Physician Orders for Life-Sustaining Treatment (POLST) form and program were originally developed in Oregon in 1991, complementing traditional advance directives, to help ensure that patient wishes to have or limit specific medical treatments are respected near the end of life.²⁻⁸ The POLST form is a

standardized set of medical orders usually developed by a coalition of citizens, healthcare professionals, healthcare agencies and organizations representing hospice, hospitals, emergency medical services, primary care and long-term care (LTC) professionals, and aging services (Figure). These orders provide guidance to first responders at the time of need, and they transfer with patients throughout the healthcare system serving as portable medical orders.

Programs based on the POLST Paradigm are now implemented throughout or in parts of 15 states. Slight modifications have been made by some states. For example, in West Virginia, the program is called Physician Orders for Scope of Treatment (POST); in New York, it is called Medical Orders for Life Sustaining Treatment (MOLST). The overarching goals are the same. POLST/POST/MOLST orders are intended for persons with advanced chronic illness who wish to turn some aspects of their advance directives or advance care plans into action at the present time to ensure that their medical treatment preferences are respected.

The National Quality Forum recommended use of the POLST program as a preferred practice for quality palliative care, noting that, "Compared with other advance directive programs, POLST more accurately conveys end-of-life preferences and yields higher adherence by medical professionals."⁹

This article outlines the elements of a POLST Paradigm Program, describes the current challenge to respect patient treatment preferences at the end of life, and offers a solution and recommendation.¹⁰

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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY		
<h2>Physician Orders for Life-Sustaining Treatment (POLST)</h2> <p><i>First follow these orders, then contact physician or NP. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.</i></p>		Last Name <hr/> First Name/ Middle Initial <hr/> Date of Birth <hr/>
A	CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing. <input type="checkbox"/> Resuscitate/CPR <input type="checkbox"/> Do Not Attempt Resuscitation (DNR/no CPR) When not in cardiopulmonary arrest, follow orders in B, C and D .	
B	MEDICAL INTERVENTIONS: Person has pulse and/or is breathing. <input type="checkbox"/> Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location. <input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care. <input type="checkbox"/> Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care. Additional Orders: _____	
C	ANTIBIOTICS <input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms. <input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs. <input type="checkbox"/> Use antibiotics if life can be prolonged. Additional Orders: _____	
D	ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible. <input type="checkbox"/> No artificial nutrition by tube. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. <input type="checkbox"/> Long-term artificial nutrition by tube. Additional Orders: _____	
SUMMARY OF MEDICAL CONDITION AND SIGNATURES		
E	Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other: _____	Summary of Medical Condition _____ _____ _____
	Print Physician / Nurse Practitioner Name _____ Physician / NP Signature (mandatory) _____	MD/DO/NP Phone Number _____ Date _____ Office Use Only _____ _____
SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED		

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Figure. Physician Orders for Life-Sustaining Treatment (POLST) form.

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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			
Signature of Person, Parent of Minor, or Guardian/Health Care Representative			
Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences. (If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)			
Signature (optional)	Name (print)	Relationship (write "self" if patient)	
Contact Information			
Surrogate (optional)	Relationship	Phone Number	
Health Care Professional Preparing Form (optional)	Preparer Title	Phone Number	Date Prepared
Directions for Health Care Professionals			
Completing POLST			
Must be completed by a health care professional based on patient preferences and medical indications.			
POLST must be signed by a physician or nurse practitioner to be valid. Verbal orders are acceptable with follow-up signature by physician or nurse practitioner in accordance with facility/community policy.			
Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.			
Using POLST			
Any incomplete section of POLST implies full treatment for that section.			
No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation."			
Oral fluids and nutrition <u>must</u> always be offered if medically feasible.			
When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).			
IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."			
Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."			
A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.			
Reviewing POLST			
This POLST should be reviewed periodically and if:			
(1) The person is transferred from one care setting or care level to another, or			
(2) There is a substantial change in the person's health status, or			
(3) The person's treatment preferences change.			
Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.			
The Oregon POLST Task Force			
The POLST program was developed by the Oregon POLST Task Force. The POLST program is administratively housed at Oregon Health & Science University's Center for Ethics in Health Care. Research about the safety and effectiveness of the POLST program is available online at < www.polst.org > or by contacting the Task Force at < polst@ohsu.edu >.			
SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED			

© CENTER FOR ETHICS IN HEALTH CARE, OHSU Form developed in conformance with Oregon Revised Statute 127.505 et seq September 2004

Figure (cont.). Physician Orders for Life-Sustaining Treatment (POLST) form.

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THE PROBLEM

Mrs. J is an elderly woman with advanced dementia who lives in a skilled nursing facility. She previously completed an advance directive requesting “do-not-resuscitate” (DNR) status and no intensive care. She has also completed paperwork appointing her daughter to make medical decisions. One Saturday night she is found unresponsive with an irregular weak pulse and very low blood pressure. Her facility is unable to reach her daughter, and emergency medical services (EMS) is called. The patient has a dysrhythmia, is resuscitated, intubated, and transferred to the nearest hospital. She is admitted to the intensive care unit and placed on a ventilator. The next morning, Mrs. J’s daughter learns what has happened and demands to know why the nursing home orders were not followed.

Why did this happen? Completing an advance directive or living will is often not sufficient to ensure that patients’ wishes to have or to limit medical treatment will be consistently respected. Advance directives are general statements of patients’ preferences but need to be carried out through specifications in medical orders when the need arises. Without special arrangements, medical orders have limited authority outside of the institutions in which they are written. For example, a physician’s orders at the nursing home usually have no authority in the ambulance or at the hospital.

THE SOLUTION

Mrs. J needed a document with medical orders that were consistently followed at each step of her care, from the nursing home to the ambulance to the emergency department to the intensive care unit. This is what the POLST Paradigm Program accomplishes. Below, we describe the system components necessary to ensure that Mrs. J receives the care she wanted, and then we return to her case to show how the outcome could have been one that respected her values and preferences.

There is strong evidence that this approach really works.^{2,9} Patients in Oregon using the POLST form virtually always have their decisions honored, even dur-

ing transfer to a hospital at the time of a serious complication.³ Patients living with serious chronic illness are advised to have their POLST form with them so that their wishes can be honored when the need arises.

APPROACH TO IMPLEMENTATION OF A POLST PARADIGM PROGRAM IN YOUR STATE

There is increasing awareness of the POLST Paradigm across the country, and many more states and communities are offering this document to summarize wishes for patients with advanced chronic illnesses and frailty in the form of physician orders. The POLST website at www.polst.org provides contact information and details about the status of POLST implementation in each state. The following steps outline the paths other states have followed to develop and implement a statewide POLST Paradigm Program:

1. Do a Needs Assessment. Is your system working well already to identify and respect patients’ preferences for end-of-life treatments? Are patients who wish to have orders to have or to limit life-sustaining treatments, such as CPR, clearly identified, and are those wishes being consistently respected? Are seriously ill patients who wish to remain at home or in a LTC facility usually able to receive comfort care in those settings, or are they often transported to the hospital? A statewide needs assessment would include surveying EMS, emergency physicians and nurses, and social workers in LTC facilities and hospitals.

2. Assemble a Core Working Group. If your data show problems in respecting patient wishes, you may wish to assemble a core group who believes that the POLST Paradigm is a good idea. By working together, members can enhance their knowledge, explain common goals to others, and enlist their participation. The video, “Your End-of-Life Prescription: Physician Orders for Life Sustaining Treatment (POLST),” describes how to build a coalition and is available on the POLST website.

3. Assemble a Task Force with Broad Representation. A statewide task force should include representatives

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from EMS, emergency physicians and nurses, LTC association and surveyors, medical association, senior services, department of health, hospital association, home health association, bar association, and hospice association. Other groups may also be considered for inclusion, such as organizations that represent health-care for seniors, representatives from minority groups, the ethics committee network, and one or more legislative champions who can provide counsel and representation regarding possible legislation. Representatives of the disability community should be considered for membership or consulted as needed to further ensure that the wishes of vulnerable patients are honored.

4. Clarify Who Should Have a POLST. Use of the POLST form is most appropriate for seriously ill persons with a terminal illness. To determine whether a POLST form should be encouraged, clinicians should ask themselves, “Would I be surprised if this person died in the next year?” If the answer is “No, I would not be surprised,” then a POLST form is appropriate. Remember that a POLST form is designed to express the individual’s preferences for levels of treatment, and can indicate either full treatment including resuscitation attempts or can be used to limit those interventions that are not desired by the individual. Unless it is the patient’s preference, use of the POLST form to limit treatment is not appropriate for persons with stable medical or functionally disabling problems who have many years of life expectancy. In the absence of a POLST form or other state-specific DNR orders, patients will receive advanced cardiac life support, including CPR, endotracheal intubation, and defibrillation, by emergency medical personnel based on standard protocols.

5. Conduct a Pilot Project. Consider conducting a voluntary pilot project in one or more communities. Enlist all local LTC facilities, EMS, emergency department personnel, hospitals, home health, and hospice. Provide training for social workers and nurses so they are better able to talk to patients and families about the POLST Paradigm form. You may wish to create a regional task force composed of representatives from

these entities and meet monthly to implement the pilot project, and then to review the results and share them with other members of the statewide task force. As your state or community develops a POLST Paradigm Program, the National POLST Paradigm Initiative Task Force is available for consultation. E-mail correspondence can be sent to polst@ohsu.edu. Once a local contact person has been identified, the task force can provide you with research and legal developments in other states, and connect you with others in your state by listing information about your state on the www.polst.org website.

6. Address Legal Issues. State laws vary and impact the process of implementation. Under your state law, can a POLST Paradigm Program be developed by state regulations, or will it require legislation? Some states have chosen the legislative route (West Virginia, Tennessee, and Hawaii) while others have followed the regulatory route (Oregon, Washington, and Utah). Consider whether you want to have the POLST Paradigm form signed by a physician only, with the patient/legal agent’s signature optional (as is the case in Oregon) or if you want the patient/legal agent’s signature mandatory (as is the case in West Virginia). Also, consider if the orders can be signed by a healthcare professional other than a physician. For example, primary care in some institutions and regions of a state may be primarily provided by nurse practitioners or physician assistants. Many programs have adopted regulations specifically authorizing nurse practitioners and physician assistants to be signers of a POLST Paradigm form. This can be a sensitive issue with some state medical associations not wanting other healthcare practitioners to have the authority to sign the form. Your coalition can address this potentially divisive issue, being both aware of and sensitive to your local political climate and existing regulations regarding scope of practice.

7. Train Healthcare Professionals. Intensive educational programs play a vital role in implementation. Train social workers, nurses, emergency medical personnel, chaplains, and others to be advance care planning facilitators to improve their skill and knowledge in

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Table: A POLST Paradigm Program

Key elements of a POLST Paradigm Program are:

- **A Protocol.** Policies and procedures for asking about patient preferences, completing a physician order (POLST form), transferring it with the patient across healthcare systems, and implementing it at each step in the transfer process.
- **A Form.** A standardized order form, signed by a physician, detailing patient wishes to have or to limit specific medical interventions such as cardiopulmonary resuscitation (CPR) and mechanical ventilation. The form is brightly colored and placed in an obvious location so that medical personnel can easily find it.
- **Education** for all parties involved: patients, families, healthcare professionals, and health systems.
- **Revision** of the POLST paradigm form and educational materials periodically based on feedback from POLST users that is sensitive to regional, cultural, legal, and other differences.
- **A System** that oversees distribution of forms, education of healthcare professionals and the public, policies and protocols that provide for continuity of orders across healthcare settings, and quality improvement to ensure that feedback from users results in enhancements to the system.

discussing, completing, and following the orders on the POLST Paradigm form. A 10-minute video entitled “POLST at Work” is available at www.polst.org and can serve as a useful educational tool to educate front-line staff. Nursing homes with growing Latino populations may also wish to have their staff view a video, “Honoring the Wishes of the Spanish Speaking Patient and Family,” which is also available on the website in both English and Spanish.

8. Program Coordination. Each statewide task force faces unique challenges in considering the best method to coordinate their program long-term, operationally and financially. Some states have chosen academic ethics centers, medical associations, or the department of health, as sometimes mandated by legislation. The best option will vary based on state-specific factors. The necessary components of the system include: (1) standardized practices, policies, and form; (2) trained advance care planning facilitators; (3) timely discussions prompted by prognosis; (4) clear, specific language on an actionable form; (5) a bright form easily found among paperwork; (6) orders honored throughout the system; and (7) quality improvement activities for continual refinement of the form and the system.

9. Distribution Plan. Determine how you plan to distribute the form. In some states, the form is downloadable from a website, with the result that data is not readily available on the extent of the form’s use, and control over printing standards is reduced. In other states, the forms are numbered and distributed from a central office, so there is close monitoring of form usage, but delays may occur in form completion. Other states distribute the forms in bulk to participating LTC facilities, doctors, hospitals, and hospice programs. The method of distribution of the form has obvious financial implications.

10. Review Program Components. We have already reviewed the requirements of a POLST Paradigm Program (also described at: <http://www.ohsu.edu/polst/coreform.shtml>). If you are developing a program but do not yet meet all the criteria, you are invited to complete the online information and submit to the national coordinating center. Your program information will be included on the website, and the area covered by your program will be colored light pink on the website’s national map. If your program meets the core requirements, you are encouraged to apply on the website for endorsement as a POLST Paradigm Program. Your information is

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reviewed by the national task force that provides feedback to our program within six weeks. Completing this information is helpful to others in your state and beyond who have similar interests.

11. Relationship with Media. Consider the interface of your program to the media. What message do you want to consistently portray? Which message do you want to avoid? Having individuals on your task force who have good public communication skills can be helpful. Thinking through a media plan and messages in advance can avoid later challenges.

12. Available Resources (see www.polst.org). The National POLST Paradigm Initiative Task Force is available to help you. Pre-courses are being offered at some national meetings, and experienced colleagues in various states are willing to provide consultation. The national task force and website can help facilitate understanding, development, education, and evaluation regarding your program, regardless of your current level of development.

RECOMMENDATION

State leaders in end-of-life care may wish to facilitate implementation of a POLST Paradigm Program at the state level and share these experiences on the www.polst.org website. The program is voluntary, and each state can make adaptations from established programs that respect legal, regional, and cultural differences.

In states lacking a statewide coalition for broad implementation, hospitals, hospices, LTC facilities, EMS, and administrative directors may consider using the POLST Paradigm Program at the regional level in their own facilities and communities. As mentioned, the ultimate goal of a POLST Paradigm Program is to ensure that the wishes of persons with advanced serious illness are honored and respected.

IMPLEMENTING POLST IN YOUR FACILITY

Assuming there are no prohibitions by state laws or regulations, facilities do not need to wait until POLST is

Website Resources

Center for Ethics in Health Care. Oregon Health & Science University. Available at: www.polst.org.

West Virginia Center for End-of-Life Care POST. Available at: www.wvendoflife.org.

Washington State Medical Association POLST. Available at: www.wsma.org/patients/pols.html.

Rochester Health Care Forum. Wide End of Life / Palliative Care Initiative/MOLST. Available at: www.compassionandsupport.org.

End-of-Life and Palliative Care Education Resource Center. Available at: www.eperc.mcw.edu.

A & A Publishers. Hard Choices for Loving People. Available at: www.hardchoices.com.

implemented within their region or state to begin to use the POLST program. Institutional champions can serve as a catalyst to the introduction and use of POLST through a grass roots approach. Key to this approach is securing administrative, medical, nursing and social service support. Next steps can include developing policies and an education plan, and notifying key contacts such as EMS and nearby hospitals. Partial implementation is often successful, as your team develops skills relating to the use of tools and having discussions with your patients. Because of the progress made in various areas of the county, those who are interested in adopting the POLST Paradigm Program can know that tools and resources are available to facilitate implementation.

THE PROBLEM REVISITED

Let's return to Mrs. J. Imagine instead that the patient's physician had completed a POLST Paradigm form with orders indicating "Do Not Attempt Resuscitation (DNR/no CPR)" in Section A and "Comfort Measures Only. Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location" in Section B.

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Following the POLST form, the nursing home's staff optimizes the patient's comfort using medications, positioning, and oxygen. The covering physician and daughter are called, who agree with the previously completed POLST orders. The daughter understands that her mother would be transferred to the hospital if for some unexpected reason her mother's comfort needs cannot be met at the nursing home. Mrs. J dies in comfort the next morning surrounded by her daughter, other family members, and staff who know her well at the nursing home.

The challenges that patients, families, and their healthcare professionals face at the end of life can be daunting. Caring and sensitive communication can elicit patients' wishes and be documented in an advance directive. To put these values into action requires an additional helpful tool, the POLST Paradigm form. Healthcare professionals and their organizations can overcome the myriad barriers to communication across systems of care by developing a POLST Paradigm Program, thereby creating a method that respects some of the most deeply held values of our patients. ✧

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References

- Hickman SE, Hammes BJ, Moss AH, Tolle SW. Hope for the future: Achieving the original intent of advance directives. *Hastings Cent Rep* 2005;35(6):S26-S30.
- Dunn PM, Schmidt TA, Carley MM, et al. A method to communicate patient preferences about medically indicated life-sustaining treatment in the out-of-hospital setting. *J Am Geriatr Soc* 1996;44:785-791.
- Tolle SW, Tilden VP, Nelson CA, Dunn PM. A prospective study of the efficacy of the physician order form for life sustaining treatment. *J Am Geriatr Soc* 1998;46(9):1097-1102.
- Lee MA, Brummel-Smith K, Meyer J, et al. Physician Orders for Life-Sustaining Treatment (POLST): Outcomes in a PACE Program. Program of all-inclusive care for the elderly. *J Am Geriatr Soc* 2000;48:1219-1225.
- Demanelis A, Moss AH. Pilot Study on POST (Physician Orders for Scope of Treatment): Report on POST form evaluations 2002. Unpublished Study. Available at: <http://www.ohsu.edu/polst/original%20research.shtml>.
- Schmidt TA, Hickman SE, Tolle SW, Brooks HS. The Physician Orders for Life-Sustaining Treatment (POLST) Program: Oregon emergency medical technicians' practical experiences and attitudes. *J Am Geriatr Soc* 2004;52:1430-1434.
- Meyers JL, Moore C, McGrory A, et al. Physician orders for life-sustaining treatment form: Honoring end-of-life directives for nursing home residents. *J Gerontol Nurs* 2004;30(9):37-46.
- Hickman SE, Tolle SW, Brummel-Smith K, Carley MM. Use of the Physician Orders for Life-Sustaining Treatment Program in Oregon nursing facilities: Beyond resuscitation status. *J Am Geriatr Soc* 2004;52:1424-1429.
- National Quality Forum. A National framework and preferred practices for palliative and hospice care quality: A consensus report. Washington, DC: National Quality Forum 2006: Available at: <http://www.nationalconsensusproject.org/Downloads.asp>. Accessed June 13, 2007.
- White House Council on Aging. Care coordination across the continuum. A WHCoA solutions forum, July 19, 2005. Available at: http://www.whcoa.gov/about/policy/meeti9ngs/Sol_forum_agenda/2005_July/07_19_05.pdf. Accessed June 13, 2007.

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MEDICARE PART D UPDATE: Freedom of Speech

Richard G. Wolfswinkel, MD, MPH, MBA, AGFP, CMO, Series Editor; Barney S. Halpern, MD, FACP, AGFP, CMO

Imagine a physician approaches a frail senior patient with the prospect of writing a prescription for the most appropriate statin for that specific patient. The physician is faced with a lot of options: treatment options — and let the patient make a decision on his or her own. Of course, to give knowledgeable advice about the healthcare system would seem to be the solution to this dilemma. This decision would be too difficult for any patient to make, let alone a nursing home resident suffering from some form of dementia, yet this is the situation that the Centers for Medicare & Medicaid Services (CMS) has set up when it comes to physicians and other providers deciding their patients for the Medicare Part D plan that provides them the best access to those medications needed for their specific patient.

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Amputation Therapy and Stroke Prevention and Treatment — Part I

Stroke continues to exert an enormous burden on the American population, with 700,000 new cases each year. While many patients die of stroke — 272,000 deaths annually are attributable to stroke — the survivors are at high risk of recurrence. For the vast majority of stroke survivors, strategies that reduce the likelihood of a second stroke are key.

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