Let's Learn about Oregon POLST and Advance Directive

OREGON ACADEMY OF FAMILY PHYSICIANS
MAKING HEALTH PRIMARY

OAFP Lunch & Learn

June 18, 2024

OHSU

Tagline: Primary Care Beyond Clinic Walls (PCBCW) would not be possible without the generous support of The Morris-Singer Foundation, the Community Health Acceleration Partnership, CareOregon, the American Board of Family Medicine, Aledade, the AAFP Foundation Family Medicine Chapter Alliance and the OHSU Department of Family Medicine.

Disclosures & Background Info

❖No financial conflicts of interest to declare

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* 2nd Cohort PCBCW

Learning Objectives

1

Differentiate Oregon POLST and Advance Directive.

2

Describe changes to the 2023 Oregon POLST form.

3

Identify those who will benefit from completing POLST and Advance Directive

Advance Care Planning Journey

Time to Get Ones Ducks in a Row!

Healthy

Name Surrogate Decision Maker

Talk to the people who matter most about the care that one want

Complete Advance Directive

Review and update after experiencing any of the "Six D's"

Complete POLST

Only when one is old/frail or seriously-ill AND one want to limit treatments

Update as needed

EOL Care Decisions

Selective Treatment

Hospice care

Comfort Measure Only Care

Less Healthy and/or Older

Ongoing Conversations and Dialogues with Loved Ones and Medical Team

Advance Care Planning

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AD/POLST Completion

Advance Directive

OFFICE OF THE DIRECTOR
Office of the State Public Health Director

Oregon Advance Directive for Health C

This Advance Directive form allows you to:

- Share your values, beliefs, goals and wishes for health care if yc express them yourself.
- . Name a person to make your health care decisions if you could nc yourself. This person is called your health care representative and act in this role.

Be sure to discuss your Advance Directive and your wishes with your resentative. This will allow them to make decisions that reflect your wish mended that you complete this entire form.

The Oregon Advance Directive for Health Care form and Your Guide to the Oregon Advance Directive are available on the Oregon Health Authority's website.

- In sections 1, 2, 5, 6 and 7 you appoint a health care representative.
- In sections 3 and 4 you provide instructions about your care.

The Advance Directive form allows you to express your preferences for health care. not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in 127.663. You can find more information about the POLST in Your Guide to the Oregon vance Directive.

This form may be used in Oregon to choose a person to make health care decisions you if you become too sick to speak for yourself or are unable to make your own medical decisions. The person is called a health care representative. If you do not have effective health care representative appointment and you become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635 (2) and this person can only decide to withhold or withdraw life sustaining treatments if you meet one of the conditions set forth in ORS 127.635 (1).

This form also allows you to express your values and beliefs with respect to health decisions and your preferences for health care.

If you have completed an advance directive in the past, this new advance directive v replace any older directive.

IMPORTANT NOTICE

VS

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POLST

- Sample -

Oregon POLST®
Portable Orders for Life-Sustaining Treatment

For Patient Education

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient's Last Name | Patient's First Name | Patient's Middle Name

Date of Birth | Gender: M F X

A CARDIOPULMONARY RESUSCITATION (CPR): Unresponsive, pulseless & not breathing

- ■ **Attempt Resuscitation/CPR** — Must check Full Treatment in Section B.
- ■ **Do Not Attempt Resuscitation/DNR** — If patient not in cardiopulmonary arrest, follow orders in B

B MEDICAL INTERVENTIONS: When patient has a pulse and is breathing.

- ■ **Comfort Measures Only.** Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
  Treatment Plan: **Provide treatments for comfort through symptom management.**
- ■ **Selective Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer to hospital if indicated.*** *Generally avoid the intensive care unit.*
  Treatment Plan: **Provide basic medical treatments.**
- ■ **Full Treatment.** In addition to care described in Comfort Measures Only and Selective Treatment, use intubation, advanced airway interventions and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit, if indicated.*
  Treatment Plan: **All treatments including breathing machine.**

Additional Orders:

C DISCUSSED WITH: (REQUIRED)

☐ Patient ☐ Parent of minor ☐ Relative, friend or other support person (without written appointment) - See reverse side for additional requirements for completion in persons with intellectual or developmental disabilities.
☐ Person appointed on advance directive
☐ Court-appointed guardian

List all names and relationship:

D PATIENT ACKNOWLEDGEMENT (RECOMMENDED BUT NOT REQUIRED)

Signature | Name (print) | Relationship (write "self" if patient)

This form will be sent to the POLST Registry unless the patient wishes to opt out. To opt out, check here.

E ATTESTATION OF MD / DO / NP / PA / ND (REQUIRED)

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's current medical condition and preferences.

Print Signing MD / DO / NP / PA / ND Name: required | Signer's Phone Number | Signer's License Number

MD / DO / NP / PA / ND Signature: required | Date: required

"Signed" means a physician signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-715-0015

SAMPLE 2023

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION D

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ACP related Documents	Advance Directive	POLST
1. Who is it for?	Anyone 18 years old and above, who has full capacity	Patients who are old or frail or seriously ill AND who may NOT want all possible treatments
2. What type of document is it?	Legal document	Medical order
3. Can you use it to appoint surrogate(s)?	Yes	No
4. Who fills it out?	Individual	Health care provider (e.g., doctor), after discussion with the patient or SDM**
5. Who signs it?	Individual, HCR*, and either 2 witnesses or a Notary Public	Health care provider (with individual or SDM**'s input)
6. Do you need a lawyer?	No	No
7. Who keeps the form?	Individual, HCR*, and health care provider	Individual, health care provider, and in the electronic Oregon POLST registry
8. Can you change the form?	Yes (as long as you have full capacity)	Yes
9. What if there is a medical emergency and you cannot speak for yourself?	Medical care team will try to honor your wishes (with or w/o) HCR*	Medical care team obtains the POLST and follows its instructions
10. Can surrogates create/sign the form?	No	Yes, with a health care provider
11. Can emergency responders use it?	No	Yes
12. Comments	It is not always easy to find the document in different health care settings. Patients must provide copies to their health care providers in every HC setting.	Upon hospital admission CODE status will be discussed. DNR on a POLST does not invoke DNR in a hospital setting.

*HCR: Health care representative

**SDM: Surrogate decision maker

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https://oregonpolst.org/

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Oregon POLST: Portable Orders for Life-Sustaining Treatment®

Oregon has served as The Founding POLST Program since the early 1990s, leading the way for greater POLST implementation.

What is a POLST?

It is a medical form that you may use to turn your wishes for treatment near the end of life into medical orders.

Who should have a POLST?

It is for a person with a serious progressive illness, such as advanced heart disease, advanced lung disease or cancer that has spread. It is also for someone who is older and frail and might not want all available medical treatments.

A POLST can never be required by a health care professional, care facility or health system.

Enter keywords here Search

Understanding POLST

Watch this simple 4-minute video to understand these medical orders.

OREGON

POLST®

Core Principles

Portable Orders for Life-Sustaining Treatment

1. A medical order written by health care providers, intended to be followed by emergency medical personnel as an **out-of-hospital** medical order set.
2. POLST is always **voluntary.**
3. POLST forms should only be completed for patients **who wish to set limits on their treatment and who have advanced illness or frailty.**
4. POLST is **unnecessary** for patients discharged to a SNF, unless the they fall under item #3.
5. POLST is **inappropriate** for healthy, older adults or patients with stable chronic disabilities.

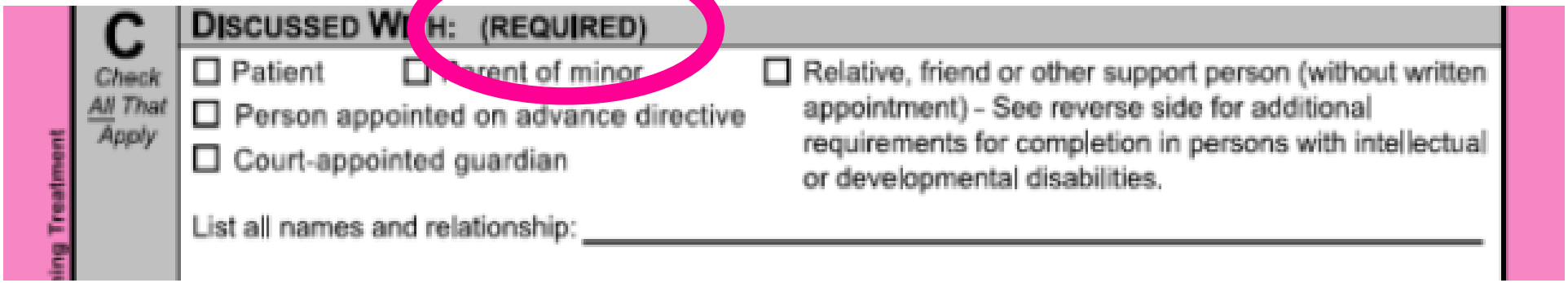
Version #14
Effective January 3, 2023

Forms submitted after **July 1, 2023,** must meet the new requirements **to be accepted into the Oregon POLST Registry.**

Or be rejected as **"Not Registry Ready [NRR]**".

16% of September 2023 POLST registry came in as "NRR."

Key and Significant Changes



C *Check All That Apply*

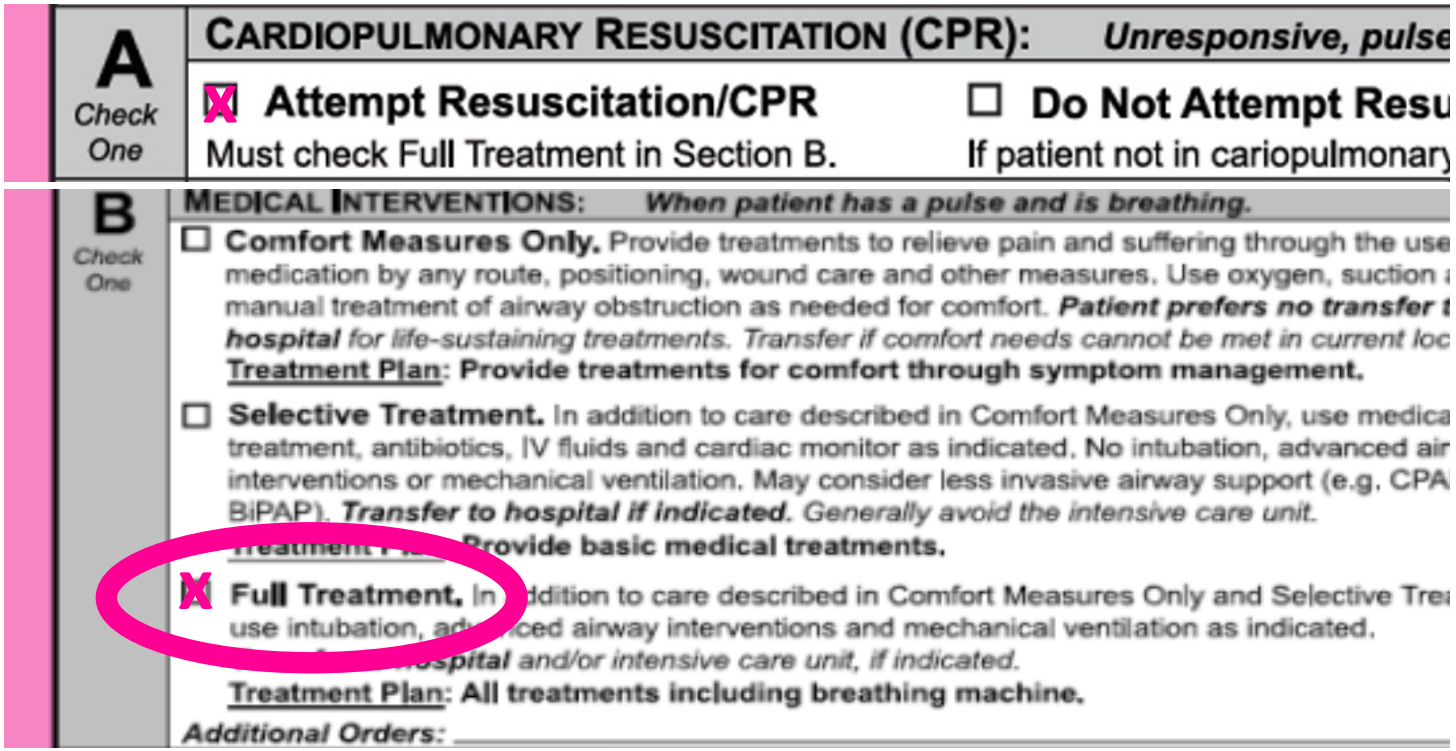
DISCUSSED WITH: (REQUIRED)

- ☐ Patient
- ☐ Parent of minor
- ☐ Person appointed on advance directive
- ☐ Court-appointed guardian
- ☐ Relative, friend or other support person (without written appointment) – See reverse side for additional requirements for completion in persons with intellectual or developmental disabilities.

List all names and relationship: _____

- Section C is now **Required.**
- Document everyone present for the conversation, including anyone who participated by phone or video.
- Requiring this documentation **reinforces** the patient's right to support person(s) for these important conversations.

Key and Significant Changes



A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***Unresponsive, pulse***

☒ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resu**

Must check Full Treatment in Section B. If patient not in cariopulmonary

B *Check One*

MEDICAL INTERVENTIONS: ***When patient has a pulse and is breathing.***

☐ **Comfort Measures Only.** Provide treatments to relieve pain and suffering through the use medication by any route, positioning, wound care and other measures. Use oxygen, suction manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current loc*

Treatment Plan: Provide treatments for comfort through symptom management.

☐ **Selective Treatment.** In addition to care described in Comfort Measures Only, use medica treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced air interventions or mechanical ventilation. May consider less invasive airway support (e.g. CPA BiPAP). ***Transfer to hospital if indicated****. Generally avoid the intensive care unit.*

Provide basic medical treatments.

☒ **Full Treatment.** In addition to care described in Comfort Measures Only and Selective Tre use intubation, ad ced airway interventions and mechanical ventilation as indicated.

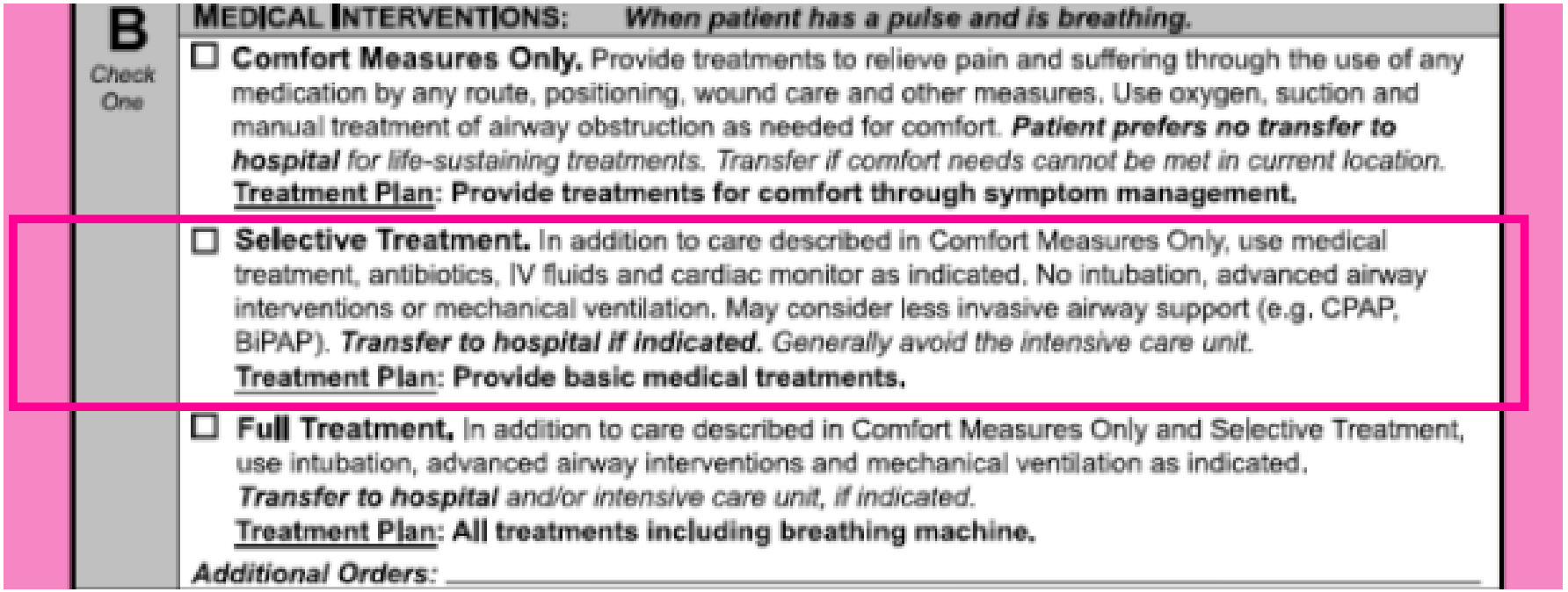
ospital and/or intensive care unit, if indicated.

Treatment Plan: All treatments including breathing machine.

Additional Orders:

If **"Attempt Resuscitation/CPR**" is selected in Section A, **"Full Treatment"** must be selected in Section B.

Key and Significant Changes



B *Check One*

MEDICAL INTERVENTIONS: ***When patient has a pulse and is breathing.***

☐ **Comfort Measures Only.** Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
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Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Selective Treatment, use intubation, advanced airway interventions and mechanical ventilation as indicated.
Transfer to hospital *and/or intensive care unit, if indicated.*
Treatment Plan: All treatments including breathing machine.

Additional Orders: _____

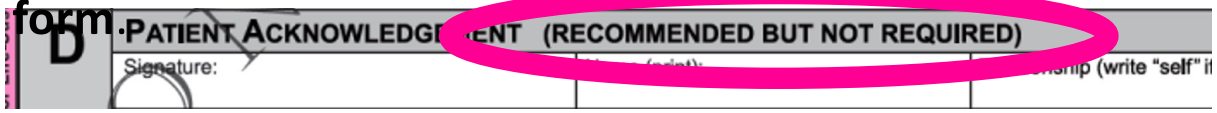
- "Limited Treatment" has been changed to **"Selective Treatment."**
- The scope of treatment options are **unchanged**.

Let's Assess What We Think We Know…

FALSE 1. If a patient has only a paper POLST form and it's not in the Registry, EMS will NOT honor the POLST form.

TRUE 2. People can have BOTH a POLST Form and an Advance Directive Form.

TRUE 3. Patients (or family/SDM/HCR, if they were the ones who completed the form) **do NOT need to sign the POLST form.**



TRUE 4. Verbal Orders can be accepted for the POLST Form.

Verbal Orders: OK Since 2018

From the 2018 Oregon POLST Registry Annual Report:

POLST form verbal order submissions and authorized signers

In 2018 the Registry began accepting forms completed by verbal order from authorized signers (MD, DO, NP, PA, ND). The Registry received 157 forms completed with a verbal order during the year. The other regulatory modification to the POLST form was addition of NDs as authorized signers. In 2018 fourteen NDs signed 56 POLST forms (range 1 to 37 forms) and represented 0.12% of all signers who submitted POLST forms to the Registry. Figure 5 illustrates the percent and number of registry ready forms submitted to the Registry by signer type in 2018.

POLST forms signed by Verbal Order

Verbal orders are useful in the care of home hospice patients. The Oregon POLST Registry will accept verbal/phone orders from M.D./D.O./N.P./P.A./N.D. in accordance with the submitting facilities' verbal order policy.

Suggested steps for Hospice

- A designated trained staff person assists a patient or surrogate decision maker to complete the POLST form.
- If the signer is not present, a verbal order for POLST is obtained from the responsible physician/nurse practitioner.
- Per their institutional/organizational policy, an authorized staff person documents the verbal order ('VORB' or 'VO' or 'TO') with the first and last name of the authorizing physician/nurse practitioner along with their name and role in the signature box, the date the order was authorized in the required date field AND LEGIBLY prints the first and last name of the authorizing physician/nurse practitioner, with license number if possible, in Section E 'Print Signing M.D./D.O./N.P./P.A./N.D. Name.' This will allow for easier and faster entry into the Registry.
- Same day submission: The staff person then takes the POLST form and using a FAX cover sheet, FAXes it to the Registry, and returns the POLST form as soon as possible to the patient's home.
- The Registry should be sent the authenticated/signed POLST form once it is available.

Guidance for Oregon's Health Care Professionals

www.oregonpolst.org

Revised December 21, 2018

Do ALL POLST Forms Need to Be "Updated"?

Preexisting POLST forms do **NOT** need to be replaced if the patient's wishes have not changed.

Same wishes = "still valid"

POLST Need to be updated every 10 years

From Guidance for Oregon's Health Care Professionals

Revised Nov 17, 2022

Purpose: Who Should Have a POLST Form?

- Patients with **advanced illness** or **frailty** where accurate predictions cannot be made but death is likely in the foreseeable future.
- If the answer is "Yes" to any of these questions:
  - ❑Does the patient have a disease process (**not just their stable disability**) that is in an advanced stage?
  - ❑Is the patient experiencing a significant decline in health (such as frequent aspiration pneumonias)?
  - ❑Is the patient in a palliative care or hospice program?
  - ❑Has this patient's level of functioning become more severely impaired, for which intervention will not significantly impact the process of decline?

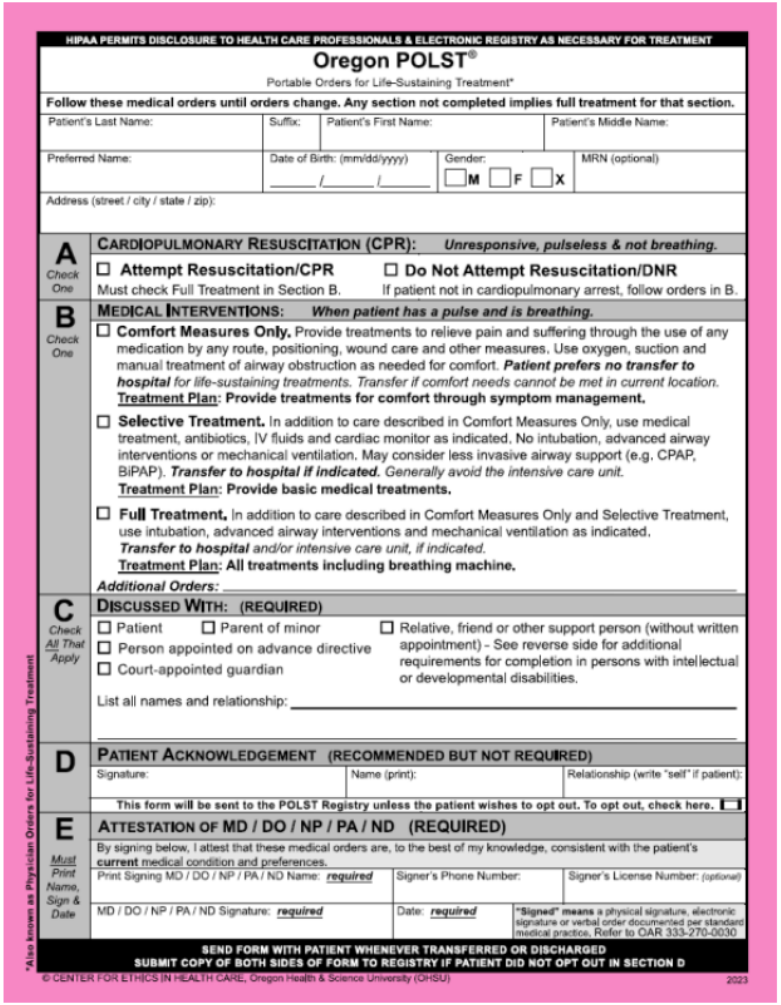
POLST: Guidance for Oregon's Health Care Professionals

Purpose: Who Should NOT Have a POLST Form?

- Patients with stable medical, or functionally disabling problems who have many years of life expectancy.
- **Patients with poor prognosis, yet if they want CPR to be attempted.**
- **Reduce the overuse of POLST among those who are "too healthy."**
  - **Unneeded** for every patient being discharged to a facility.
  - **Should NOT** be completed for healthy patients at Medicare wellness visits.
  - **Inappropriate** for healthy individuals who would want everything done in an emergency.

Let's Review The POLST Form

Section by Section



HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Oregon POLST®

Portable Orders for Life-Sustaining Treatment*

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient's Last Name: | Suffix: | Patient's First Name: | Patient's Middle Name:

Preferred Name: | Date of Birth: (mm/dd/yyyy) ____/____/____ | Gender: ☐M ☐F ☐X | MRN (optional)

Address (street / city / state / zip):

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *Unresponsive, pulseless & not breathing.*

☐ **Attempt Resuscitation/CPR** — Must check Full Treatment in Section B.

☐ **Do Not Attempt Resuscitation/DNR** — If patient not in cardiopulmonary arrest, follow orders in B.

B Check One — **MEDICAL INTERVENTIONS:** *When patient has a pulse and is breathing.*

☐ **Comfort Measures Only.** Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: **Provide treatments for comfort through symptom management.**

☐ **Selective Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer to hospital if indicated.*** *Generally avoid the intensive care unit.*
Treatment Plan: **Provide basic medical treatments.**

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Selective Treatment, use intubation, advanced airway interventions and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit, if indicated.*
Treatment Plan: **All treatments including breathing machine.**

Additional Orders: _____

C Check All That Apply — **DISCUSSED WITH: (REQUIRED)**

☐ Patient ☐ Parent of minor ☐ Person appointed on advance directive ☐ Court-appointed guardian ☐ Relative, friend or other support person (without written appointment) - See reverse side for additional requirements for completion in persons with intellectual or developmental disabilities.

List all names and relationship: _____

D — **PATIENT ACKNOWLEDGEMENT (RECOMMENDED BUT NOT REQUIRED)**

Signature: | Name (print): | Relationship (write "self" if patient):

This form will be sent to the POLST Registry unless the patient wishes to opt out. To opt out, check here. ☐

E Must Print Name, Sign & Date — **ATTESTATION OF MD / DO / NP / PA / ND (REQUIRED)**

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's **current** medical condition and preferences.

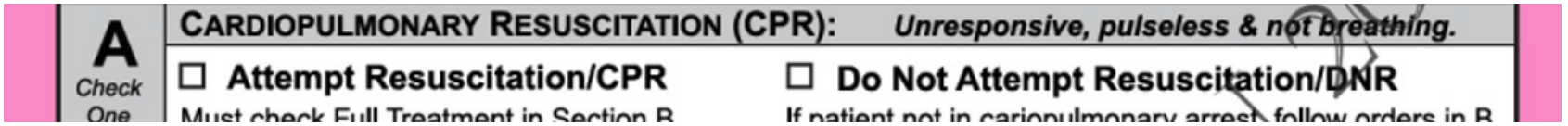
Print Signing MD / DO / NP / PA / ND Name: ***required*** | Signer's Phone Number: | Signer's License Number: *(optional)*

MD / DO / NP / PA / ND Signature: ***required*** | Date: ***required*** | **"Signed" means** a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0030

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION D

*Also known as Physician Orders for Life-Sustaining Treatment

Section A: Cardiopulmonary Resuscitation (CPR)



Apply only when the patient is unresponsive, pulseless, and not breathing (Dead)

❑ **Attempt Resuscitation/CPR**
(RARELY should be used this way)

- If the patient **wants** emergency personnel to attempt CPR, check this box.

❑ **Do Not Attempt Resuscitation/DNR**
(POLST is mainly for this purpose)

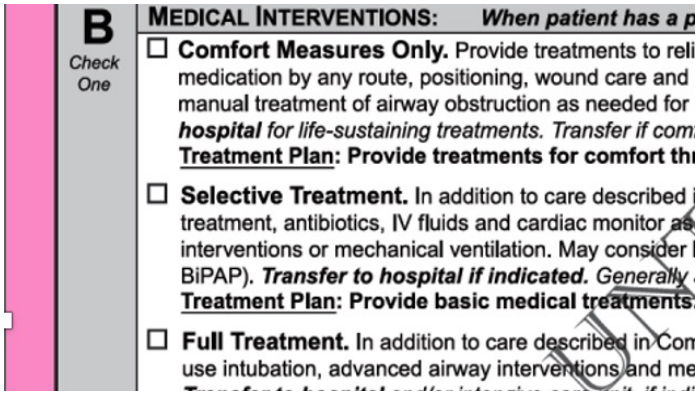
- If the patient has indicated that they do not want CPR attempted in the event that there is no pulse or breathing, check this box.

CPR on a 92 Year Old Male with Metastatic Malignancy

Tracy A. Brader, a third-year resident in Emergency Medicine at Christiana Care in Newark, Delaware, published this painting in the AMA Journal of Ethics. [2018;20(8):E774-775]

Section B: Medical Interventions

Apply Only to Patients with a Pulse and Breathing (Alive)



B
Check One

MEDICAL INTERVENTIONS: *When patient has a p*

☐ **Comfort Measures Only.** Provide treatments to reli
medication by any route, positioning, wound care and
manual treatment of airway obstruction as needed for
hospital *for life-sustaining treatments. Transfer if com*
Treatment Plan: Provide treatments for comfort thr

☐ **Selective Treatment.** In addition to care described
treatment, antibiotics, IV fluids and cardiac monitor as
interventions or mechanical ventilation. May consider
BiPAP). ***Transfer to hospital if indicated.*** *Generally*
Treatment Plan: Provide basic medical treatments

☐ **Full Treatment.** In addition to care described in Com
use intubation, advanced airway interventions and me

❑ **Comfort Measures Only**

- Goals: **maximize comfort, symptom management** and **avoid hospitalization** (unless necessary to ensure meeting comfort needs)
- ***A care plan model (hospice care or a long-term care facility setting where CMO care can be provided) is strongly recommended.***

❑ **Selective Treatment**

- Desires being hospitalized if needed, **avoid mechanical ventilation,** and generally **avoid the intensive care unit**.

❑ **Full Treatment**

- Desires all life-sustaining treatments: intubation, advanced airway interventions, and mechanical ventilation - as indicated. Transfer to hospital and/or intensive care unit, if indicated. No limits to treatment.

Section B: Medical Interventions

Additional Orders: _____

Additional clarifying orders to the patient's preferences can be written.

Examples;

- *"Patient wishes to continue blood transfusions if appropriate."*
- *"Intubation for 1-2 weeks."*
- *"No tracheostomy."*
- *"No Feeding-Tube!!" or "Tube feeding ok for a month."*

- **What about Dialysis?**

Appropriate Section A and B Combinations as of July 1, 2023

Section A Section B	Comfort Measures Only	Selective Treatment	Full Treatment
CPR	X	X	○
DNR	○	○	○

When a Patient Wants to Limit Treatments....

Is it wrong to simply follow what the patient says?

Isn't it their decision NOT to receive treatments?

"I just want to be comfortable."

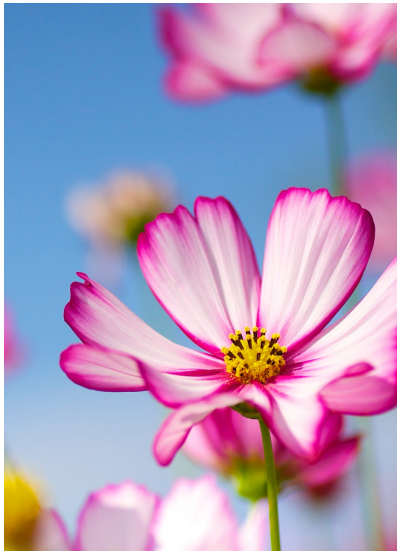
"I don't want to be hooked up to machines."

Case 1

- 93 yo female "Ruth" with HFrEF (EF< 20%), HTN, CKD3b, A-fib on DOAC, lives alone at home, supported by her neighbors. Recently, she was admitted to the hospital due to cholecystitis, which was medically treated (surgery was deemed to be too high a risk), yet surprisingly was doing well.
- She completed her AD several years ago and her HCR is her grandson, who lives in the next town over (no other family members).
- She also completed her **POLST a couple of years ago with DNR/CMO**.
- Her neighbors brought her to the hospital due to a couple of days of nausea/vomiting and found her with decreased mental status. In the ED, she was found to be hypotensive (SBP in 70-80s), tachycardic with significantly elevated liver enzymes and AKI.
- Her neighbors told the ED physician that they were very sure that Ruth would want to be treated, yet the ED physician tried to honor her POLST (DNR/CMO), rather than admitting her to ICU, and tried to reach her grandson but was not successful.
- Admitted to a medical floor, "planning to transition to CMO"...when her grandson was reached by a hospitalist and agreed to have her continue with the current care, but not to a CMO status or an ICU admission.
- ***But..... Ruth appears to be dying.....?!***

Case 1 (continued)

- The provider spoke with her neighbors, who shared that Ruth was lately unhappy with her grandson, as he was often unavailable. They were also very clear and sure that Ruth would want to pursue any treatments to live (except for intubation or CPR) and they requested that she be transferred to ICU.
- Later, the provider was able to reach the grandson by phone and explained her medical situation and what Ruth's neighbor friends had said regarding her wishes, and he agreed to transfer her to ICU.
- Fortunately, Ruth also woke up (!) around the same time, saying ***"Of course, take me to ICU!"***
- Not surprisingly, her renal function tanked and became anuric. She opted to pursue dialysis(!!) when offered, and began CRRT (Continuous Renal Replacement Therapy) with pressors.
- Eventually, her grandson joined her at her bedside.
- **On Ruth's third day on CRRT, she passed away in ICU**.



What are Your Key Takeaways from the Case as a Provider?

- **Think twice if patients are requesting 'CMO'.**
  1. **Is 'CMO' medically appropriate for the patient and do they understand what this means?**
  2. **Can we carry out the 'CMO' plan during an emergency without requiring an acute care setting?**

  If CMO patients end up in ED/hospital/ICU (frequently), ***why do we even complete POLST (CMO)? → HARM to both patients and clinicians...!?***
- Recommend that patients review their AD and update it as needed, choosing an appropriate HCR!
- Ongoing conversations with the HCR are the most important aspect of an ACP!

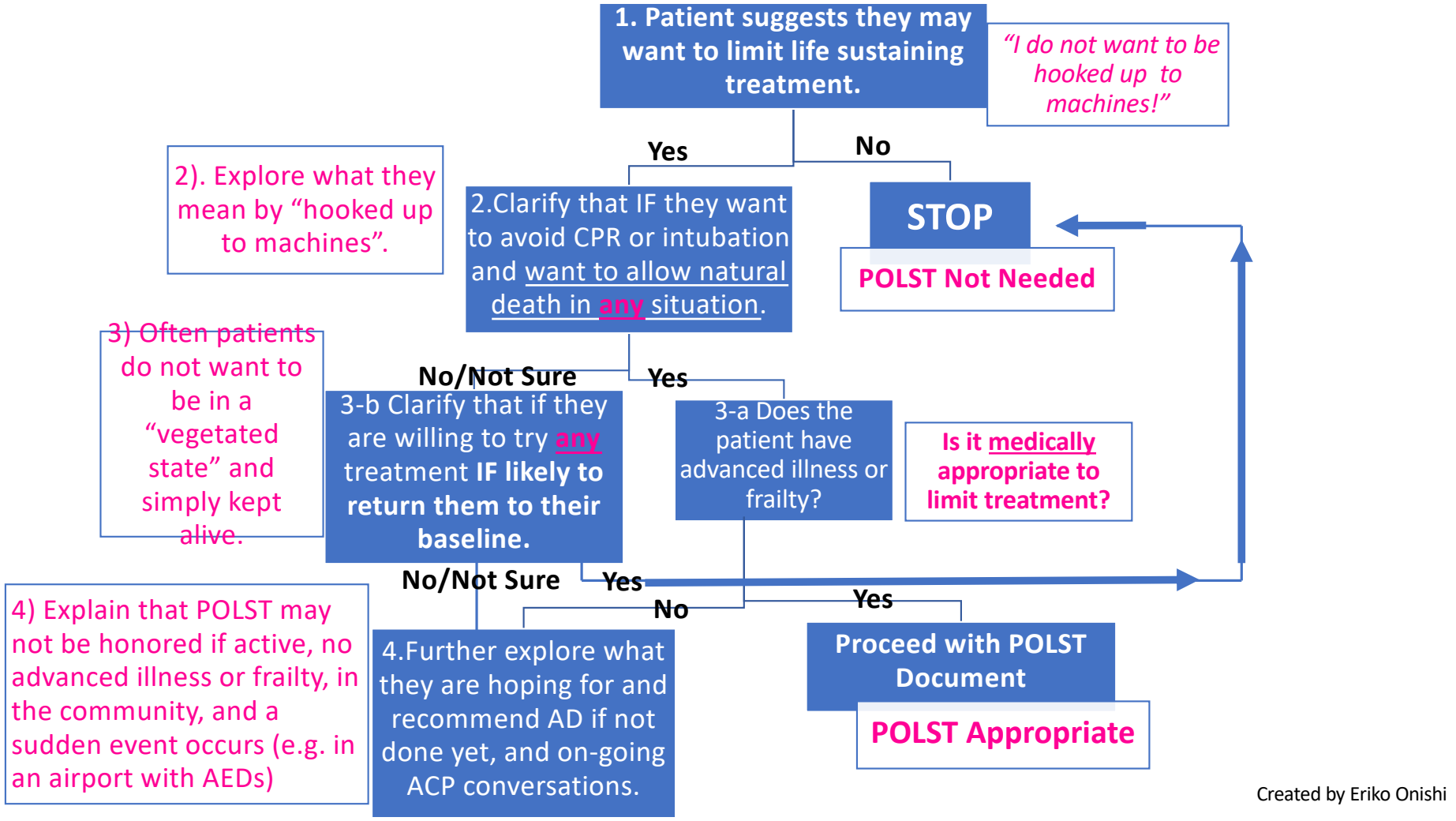
Case 2

68-year-old male “ Joe” has controlled HTN and HLD and lives with his wife at home. He recently retired and continues to be very active in the community, jogging regularly, and traveling internationally for pleasure.

Joe came in for his Medicare Wellness Exam and, while discussing ACP with him, he shared that, “I would never want to be hooked up to machines!”

What is your next step?

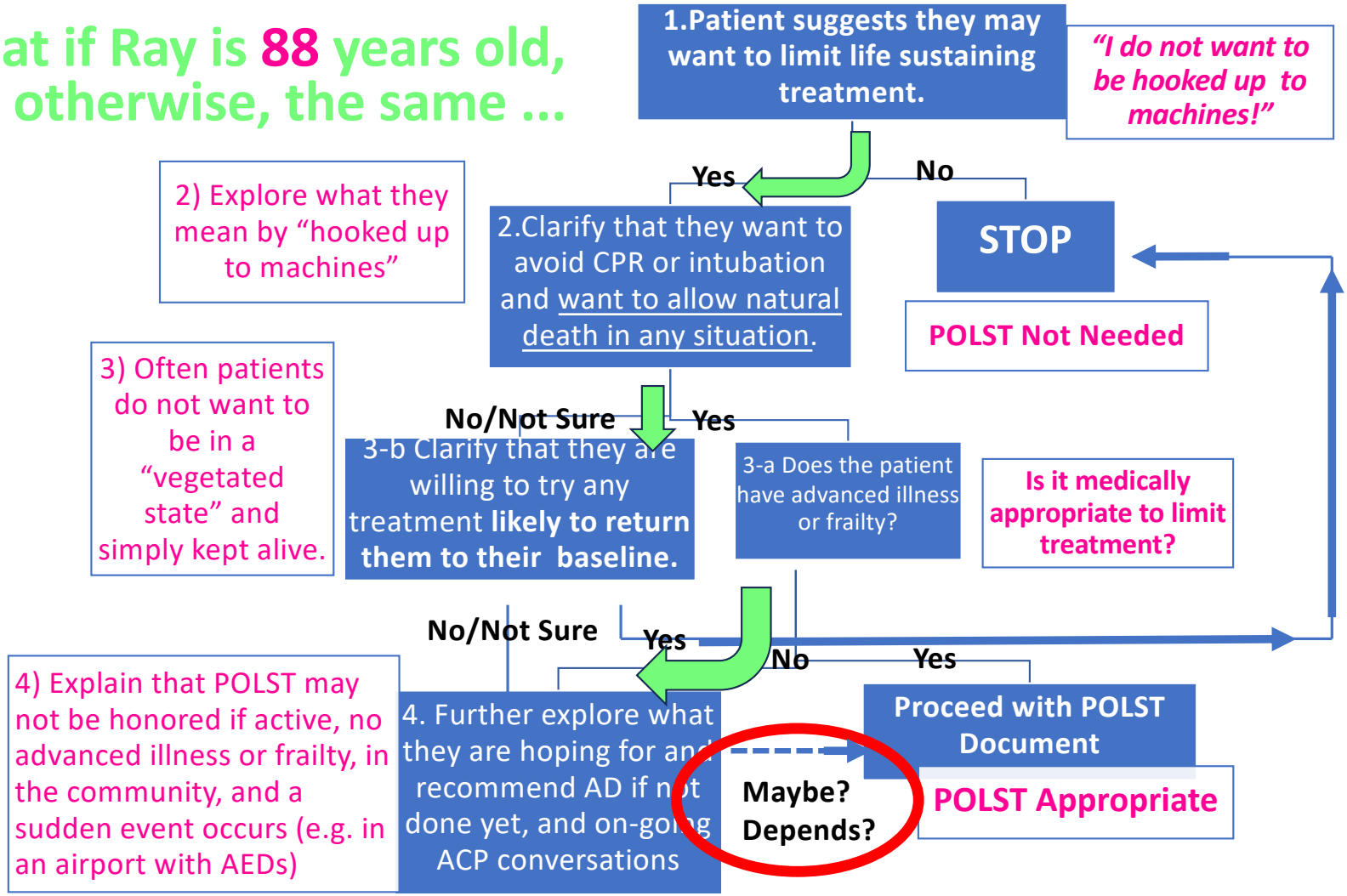
Algorithm: When to Do or Not Do a POLST



Created by Eriko Onishi

Algorithm: When to Do or Not Do a POLST

What if Ray is 88 years old, but otherwise, the same ...



Created by Eriko Onishi

Advance Directives (AD)

- ***Documents*** completed while a person is still possessing full decisional capacity regarding treatment decisions, made in the event that they lose the capacity to make such decisions
- **Legal tools** → allows one person to designate another to make their health care decisions = ***Health Care Representative***
- An individual can **document their wishes** as to the ***types of medical treatments*** that they would or would not want in an end-of-life situation
- AD is **only followed** after a person has lost their ability to make decisions
- ADs can **be revoked orally by the patient** at any time (as long as they still have decisional capacity)

What does the Oregon Advance Directive Do?

1. Appoints a Health Care Representative

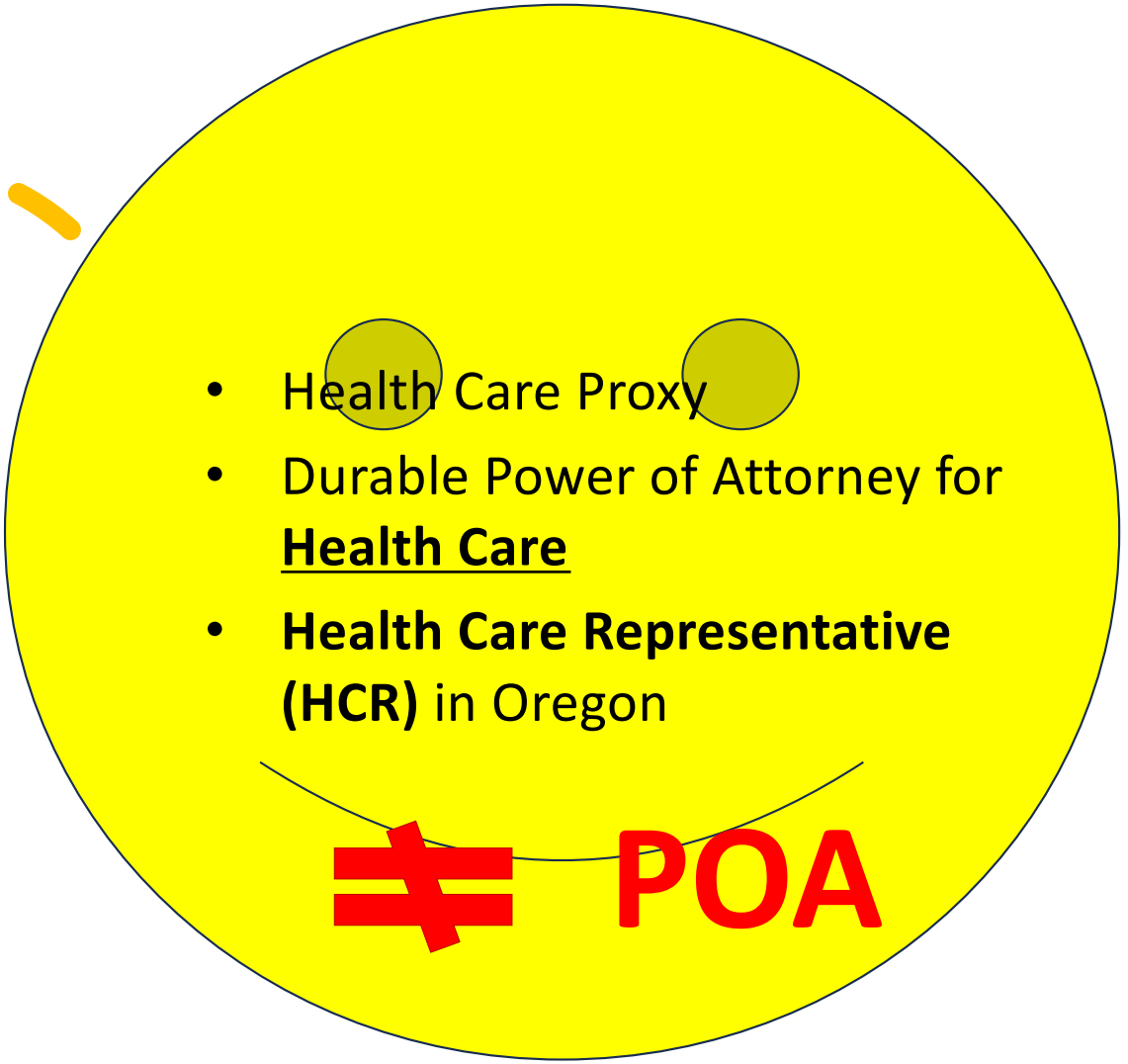
- Oregon allows you to appoint up to **3** representatives,
- One **primary** and **two alternates (optional)**,
- Only one can serve at a time.

2. Provides written medical instructions, based on personal preferences

- Can choose the options presented in the multiple-choice form,
- Can write own narratives,
- Can attach a supplementary document as an official part of one's Advance Directive instructions.

Surrogate Decision Makers

Terminology



Case Example

Who is the surrogate decision maker?

68 y/o male who was admitted to the hospital for altered mental status change. Under the chart review, you identified his potential surrogate decision maker(s) as the following: significant other of 17 years (not married), 3 sisters who live out of state with no contact information, and an incarcerated adult son who has been estranged from the patient for the past 10 years. Patient has no AD and does not have medical decision-making capacity.

Who Makes Decisions if You Don't Have a Health Care Representative?

Oregon: ORS 127.635
Withdrawal of life-sustaining procedures

… if the principal **does not have an appointed health care representative or applicable valid advance directive,** the principal's health care representative shall be the first of the following, in the following order, who can be located with reasonable effort by the health care facility and who is willing to serve as the health care representative:

(a) A **guardian** of the principal who is authorized to make health care decisions, if any;
(b) The principal's **spouse**;
(c) An adult designated by the others listed in this subsection who can be so located, if no person listed in this subsection objects to the designation;
(d) A majority of the **adult children** of the principal who can be so located;
(e) Either **parent** of the principal;
(f) A majority of the **adult siblings** of the principal who can be located with reasonable effort; or
(g) Any adult relative or adult friend.

If none of these are available, *life-sustaining procedures may be withheld or withdrawn on the direction and* ***under the supervision of the attending physician or attending health care provider.***

When to Strongly Recommend a Patient to Complete an AD?

1. If a patient's chosen SDM is **NOT** the one identified by ORS 127.635.
2. If a patient is not adherent/compliant with some procedures, interventions or treatments.
3. If a patients says, **"Do everything!" (Full code),** but CPR is NOT medically indicated. (Explore what "Do everything!" means first.)
4. If a patient shares that they would never want to be on life-support or they have specific views/beliefs on the matter.
5. If a patient has not talked with their SDMs/loved ones/family regarding their wishes.
6. If a patient does not identify any SDM.

When to Update your Advance Directive:

... after you experience any of the "Six D's"

Decade: At each new decade of your life

Death: When a loved one or a health care representative dies

Disagreement: When your health care representative does not agree with your wishes

Divorce: If you separate from a spouse or domestic partner who is your Advance Directive representative, you must complete a new Advance Directive EVEN IF you want them to continue serving as your representative

Diagnosis: When you are diagnosed with a serious illness or **D**ementia (in early stage)

Decline: When your health declines or you can no longer live on your own

FAQ

Legal validity of the AD

AD from different states is valid. (ORS 127.515(6))

Instrument presumed valid. (ORS127.575)

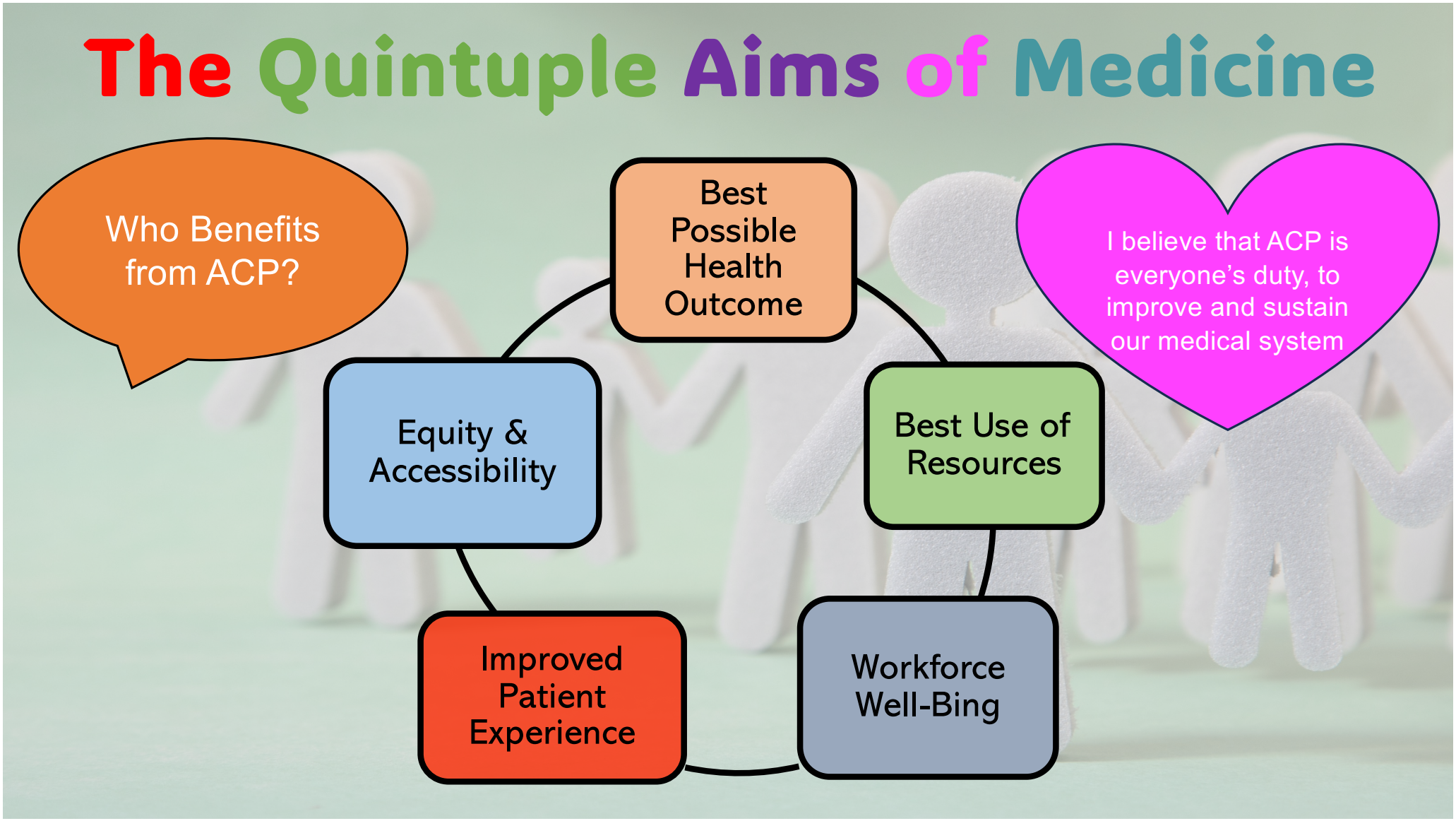
Best practice is to complete AD for each state the principle resides.

Witness signatures are dated different from principles' signature is valid. (ORS 127.515 (3, 4))

Dementia patients and AD (Capacity evaluation maybe needed, yet does not mean that the principle needs to have complexed medical decision capacity when completing an AD)

HCRs do **NOT** need to ***sign*** the AD, needs to ***accept*** appointment. (ORS 127.525)

The Quintuple Aims of Medicine



summary

Comments or questions

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Thank you!

1. A POLST form is a medical order. To be a **meaningful order**, each health care professional should complete the POLST form carefully and accurately, reflecting patient preferences, with medical indications.
2. Strongly consider having clear care plans (e.g. Hospice) when choosing a CMO, so the plan can be followed without requiring ED visits/hospitalizations. → **reduces both harm to patients and confusion for clinicians**→ **increases the utility and value of the POLST!**
3. Always explore and **ask 'why?',** whenever patients are considering limiting their future treatments, especially if they do not have advanced illnesses or frailty.
4. POLST (like US medicine generally) attempts to prioritize patient autonomy, but the ideal initial decision-making process should always include clinician input. This applies **both** to when patients limit their treatment in a medically-inappropriate way, **and** when they request medically-inappropriate CPR → **Explore/Discuss → improves patients' trust in their health care team!**
5. Strongly recommend an AD for any patient who could significantly benefit from it.