

OREGON POLST™

Recommendations for POLST™ Elements

Introduction and Background

Physician Orders for Life-Sustaining Treatment (POLST) is more than a piece of paper or a set of data fields in an electronic registry. Instead, it is part of a larger cultural phenomenon; education, sensitive communication, accurate and timely recording and retrieval, and a system based on trust, which aims to ultimately honor a person's wishes for care as they near the end of life.

Over the past 25 years, the Oregon POLST Coalition has made many changes to Oregon's POLST form to improve its effectiveness. These changes are based on clinical experience and rigorous quality improvement research. Recently, our coalition was asked by the National POLST Office to provide an explanation of the 12 major revisions of the Oregon POLST form. This document provides the opportunity to share such form changes to help the National POLST Office and POLST leaders in other states with the development of POLST-like programs.

Oregon's experience with POLST form revision reflects complexity and nuance; blending emerging advances in technology, clinical events, research, legal and regulatory changes and cultural evolution. Understanding that national colleagues are considering the development of a uniform POLST-like form that could apply across all states, we start with a word of caution, followed by a description of our major POLST form changes over the years.

Each State Should Create a POLST-Like Form and Program that Meets the Unique Needs of that State

Each state's POLST program is guided by their particular regulations and laws, the program being a reflection of the unique culture of that state. Program founders must thoughtfully weave these factors into a sustainable program of the highest quality. Some, including the National POLST Office, have considered developing a uniform POLST-like document that could be implemented nationally. Because of the unique legal, regulatory and cultural features of each state we feel that the development of a national form would ultimately be unsuccessful and is an unwise direction. Instead, the Oregon POLST Coalition feels that the substantial resources state leaders spend developing agreement on a uniform document would be better spent on addressing problems with POLST program quality in each of our states.

The most pressing issue facing POLST programs today are growing quality concerns in assuring that POLST use remains both *informed and voluntary*. Such concerns are demanding significant form changes at a greater frequency now than at any point in the 25 year history of the POLST effort. For example, Oregon implemented the 12th version of the POLST form in early 2018 and is currently working on major changes for version 13. These revisions are based on our coalition's [Quality Improvement Committee](#) recommendations utilizing data from the [Oregon POLST Registry](#). Putting substantial effort into the creation of a uniform document detracts from the need to be nimble. Programs must have the ability to respond effectively to a growing number of quality concerns as well as advances in medical knowledge.

Further, one unfounded value of a uniform document is to ensure that medical orders have reciprocity

across state lines. In the rare case in which a POLST-like document is presented in caring for a person from another state, these orders are honored by the care team. The Oregon POLST Program is not aware of a single instance where the orders on a document were not honored because it was on another state's POLST-like form.

A Review of Oregon POLST Form Revisions

This summary includes a review of the rationale underlying the major changes in the 12 POLST form revisions the Oregon POLST Program has made between 1993 and 2018. This summary does not review core elements that are widely accepted and instead highlights areas in need of improvement. The recommendations include the need to focus on more than form dissemination and form elements when building and sustaining an effective, high-quality POLST program.

1) Preserving voluntariness and informed decision making

- a) Avoid both financial quality incentives and other methods of counting/recording the number of POLST forms completed.
 - i) Health systems should not use or implement electronic health record (EHR) alerts or electronic preset options that encourage POLST completion as an option at age 65. This encourages the premature completion of POLST when an advance directive would be the more appropriate document to offer.
 - ii) The Oregon POLST Quality Improvement Committee is addressing two pressing issues in the overuse of POLST.
 1. There is a myth that POLST is required for patients admitted to a skilled nursing facility including those admitted for short term rehabilitation (some of whom are “too healthy” to have a POLST form). The Oregon POLST Program recommends integrating a [standard code status option](#) for those who are “too healthy” for a POLST on hospital discharge forms instead of defaulting to a POLST for all of those discharged to skilled nursing and short term rehabilitation. This recommendation meets the facilities need for code status orders without promoting premature completion of POLST.
 2. When POLST forms are counted as one way to satisfy advance care planning (ACP) quality measures at a specific age, the Oregon POLST Program receives increased complaints from facility patients feeling “pressured” to complete a POLST. When POLST is among several options that are counted to meet an ACP quality measure, some health care professionals report that POLST completion is the “easiest path” to meet the metric and acknowledge completing POLST forms for patients beyond the intended population.
- b) Build a robust Quality Improvement Plan prior to launching a POLST program.
 - i) The [Oregon POLST Quality Improvement Committee](#) has assumed an expanded role to monitor and address quality issues that include voluntariness (“feeling pressured”), inadequate informed consent, use in inappropriate populations, and underuse.
- c) Empower patients and surrogates by developing educational materials that promote informed and effective decision makers.
 - i) Materials need to be created with attention to health literacy principles, different learning styles, language and cultural backgrounds. Stories have proven to be a particularly effective way to provide patient education ([Patient and Family Resource Library](#)).
- d) Do not mandate patient or surrogate signature.

- i) Having a patient or surrogate sign does not preserve either *voluntariness or informed* decision making in the context of [incentives](#). Also, requiring a patient signature confuses advance directives with POLST as medical orders are not signed by patients.
- 2) Avoid mandated and time based review processes (removed from POLST form in the 2004 version)
Respect the need for longer duration POLST forms for those with frailty than the surprise question would suggest are POLST eligible.
 - 3) Assure that Nurse Practitioners (NP) and Physician Assistants (PA) can sign POLST forms
 - a) The original Oregon POLST™ form allowed only physician signers (MD/DO). In [2001](#), nurse practitioners became authorized signers with physician assistants included in [2007](#). Oregon strongly supports authorizing NP and PA signing privileges (“[The Role of Advanced Practice Registered Nurses in the Completion of Physician Orders for Life-Sustaining Treatment](#)”).
 - b) It is useful to retain “orders” in the POLST name. The Oregon POLST Program recognizes that using the word “physician” in the description of POLST is not inclusive of all disciplines currently authorized to sign POLST orders. We have found it useful to retain the intent of the name, which indicates the distinction between an advance directive authorized by a patient and POLST as medical orders authorized by a health care professional. Thus, retaining the word “orders” assists in clarifying an important distinction between these two documents. Oregon now illustrates the function of the Oregon POLST™ document as portable medical orders in educational materials.
 - 4) Do not require a POLST form to have an order section about Antibiotics or a section about Artificial Nutrition and Hydration.
 - a) Section B of the Oregon POLST form with options for three levels of treatment should be retained. This section has been strongly associated with care received and location of death.
 - i) Several studies have demonstrated an association between the level of treatment ordered and the treatments patients ultimately receive (“[A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program](#)”). For those with orders for Comfort Measures Only, there is a 6.4% rate of death in the hospital (“[Association Between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon](#)”).
 - b) The section related to Antibiotics was removed from the Oregon POLST™ form in [2011](#) as there is no standard definition for “use antibiotics for comfort” and the rates of antibiotic use were not different irrespective of the orders to have or to limit antibiotics (“[The Consistency Between Treatments Provided to Nursing Facility Residents and Orders on the Physician Orders for Life-Sustaining Treatment \(POLST\) Form](#)”).
 - c) The artificial nutrition and hydration section of the POLST form was originally created to promote planning in the context of advancing dementia. In the early 1990s when Oregon created the POLST program, it was thought that placement of a feeding tube extended life for those with advanced dementia; now we know this is not true. (“[American Geriatrics Society Feeding Tubes in Advanced Dementia Position Statement](#)”). [New data](#) suggests that the section on artificial nutrition and hydration should not be a required POLST form element. Given these developments, the Oregon POLST Coalition has approved [removal of Section C \(Artificially Administered Nutrition\)](#) from future versions of the Oregon POLST form. Statewide education

about the science behind feeding tube utility is encouraged leading to Oregon being tied for the lowest rate of feeding tube placement in advanced dementia ([Dartmouth Atlas](#)).

5) Be able to locate current POLST orders rapidly

- a) Develop a statewide POLST registry embedded in the Emergency Medical Services (EMS)/trauma system.
 - i) EMS needs actionable medical orders as they cannot independently implement an advance directive in the field ("[POLST: When Advance Directives Are Not Enough](#)"). Oregon's extensive review demonstrated that including advance directives in the Oregon POLST Registry would not be cost effective ([OPR Fact Sheet](#)).
 - ii) The Oregon POLST Coalition recommendations include that the Registry be integrated into the workflow of both EMS and primary care and that EHRs have single sign-on and one-click access.
- b) Mandate submission to the POLST Registry unless the patient wishes to opt out.
 - i) Submission to the Oregon POLST Registry is a statutory obligation of the signer unless the patient wishes to opt out ([HB 2009](#) section 1184). Having a mandate to submit substantially increases the use and value of the Registry ("[The Quality of POLST Completion to Guide Treatment: A 2-State Study](#)" and [OPR 2017 Annual Report](#)). Failure to submit to the Registry compromises access to POLST orders in a crisis.
- c) POLST programs and registries develop to meet clinical needs within a given state.
 - i) Each program is guided by the particular policies and laws of that state. Registries, as an extension of a POLST program, are designed within, and subject to, these same statutes and to emergency medicine infrastructure. Developing a national registry would require addressing the requirements of each state's laws and risk a lack of thorough integration within the emergency medical system and EHR systems within the state. Free standing registries such as that developed by the state of Washington have been far less effective than the tightly integrated system Oregon has developed.
- d) Provide single click access from the header in the EHR
 - i. The [Oregon POLST Registry](#) is a backup system. It is encouraged that all Oregon EHR systems retain a copy of POLST and advance directives separately on the patient header, with one-click access to POLST forms to enhance access to forms in a crisis. The chance of error is further reduced when an EHR has bidirectional communication with the Registry. This was illustrated in last year's Kaiser Health News article ("[In Oregon, End-of-Life Wishes Are Just A Click Away](#)"). Even when the document is available in one-click, the remaining challenge is assuring POLST is reviewed by health care professionals in a timely manner. There are electronic interventions which may be helpful. For example, linking POLST forms to code status orders in the EHR so that during the hospital admission process staff receive an alert that a POLST form exists.
- e) Be able to easily void and revise POLST forms.
 - i. POLST forms are often revised as wishes change near the time of death ("[Timing of POLST Form Completion by Cause of Death](#)").

6) Assure adequate education for health care professionals and lay community members.

- a) Prior to program launch, conduct ongoing statewide education and provide innovative options for adult learning to target specific behavior changes ([Oregon POLST Professional Resource Library](#)).

- i. Ongoing education is imperative. The Oregon Health & Science University (OHSU) Center for Ethics in Health Care (the administrator of the Oregon POLST Program) sponsors ongoing [statewide](#) POLST education and training to enhance the skills of those having goals of care conversations (“[Lessons from Oregon in Embracing Complexity in End-of-Life Care](#)”).
 - 1. The [Oregon POLST website](#) is primarily used as a repository for educational materials for [health care professionals](#) and [patients and families](#). The Oregon POLST Program also utilizes [YouTube](#) and other forms of [social media](#) to promote educational videos.
 - 2. Most POLST forms in Oregon are completed by primary care professionals (“[The Oncology Specialist’s Role in POLST Form Completion](#)”). Often planning occurs in the primary care outpatient setting over multiple visits prior to POLST completion and the meaningful goals of care conversation payment 30-minute time requirement is not met in any single visit. (“[POLST: When is the Right Time?](#)”)
 - 3. POLST Programs Need to Reflect the Culture of the Community. The Education Committee was established to synthesize, review, and distribute educational material for health care professionals across care settings. The Community Insight Committee was convened to expand the use of patient stories to educate the public about the role and relationship of POLST and advance directives.
- b) Set standards for health care professional communication skills. Partner with health professions schools to transform medical education to “raise the bar” and require communications skills testing as a medical school graduation requirement. Advocate for communication skills testing as part of certification for those who care for seriously ill patients.
 - i. OHSU has raised the bar in 2018 by requiring communications skills testing of graduating medical students (“[Learning to share tough news -- the compassionate way](#)”).
 - ii. As other states create POLST-like registries, Oregon encourages implementation of each of the robust quality and access standards under which the [Oregon POLST Registry](#) operates and the ongoing statewide education of EMS professionals.