Oregon POLST® - Archived History

1990: Oregon POLST Task Force Founded on Strong Guiding Principles

In 1990, Oregon leaders in clinical ethics, emergency medical services and long-term care recognized that preferences for life-sustaining treatments of patients with advanced chronic progressive illness were frequently not found or not transferable and thus not honored. Under the leadership of Dr. Patrick Dunn, a Task Force was convened by the Center for Ethics in Health Care at Oregon Health & Science University (OHSU) with representatives of stakeholder health care organizations to develop a new method to translate patient preferences into actionable medical orders that follow patients across settings of care.

The newly formed volunteer Task Force was founded on strong guiding principles of always working for the benefit of patients, using an open consensus process inviting interested parties to the table, using a continuous quality improvement process that welcomes critical feedback with the goal of seeking truth, and avoiding and managing conflicts of interest.

Dr. Susan Tolle, Director of the Center for Ethics in Health Care at OHSU, has led funding efforts for the Oregon POLST Task Force. Support has come from private donations and grants. Funding from health care industry sources was specifically excluded to avoid any perceived, potential or actual conflicts of interest.

1991: Building a Coalition

In 1991, it was not uncommon for ill Oregonians nearing the end of life to receive unwanted medical treatment. To address this problem, The Center for Ethics convened a group of health care professionals including emergency medical services (EMS), medicine, nursing, hospice, and long-term care. Over a two-year period, the newly formed Task Force developed the Medical Treatment Coversheet (MTC); designed to help health care professionals honor the treatment preferences of their patients.

Members of the 1992 Task Force that Developed and Evaluated the Medical Treatment Coversheet

- Johnna Alexander, Oregon Health Decisions
- Karen Art, Department of Justice
- Holly Berman, Multnomah County Aging Services Division
- Ray Broomfield, Oregon Fire Chiefs Association
- Ann Brown, MD, American College of Emergency Physicians
- Margaret Carley, JD, Oregon Health Care Association
- Jim Davis, Oregon Council of Senior Citizens

- Maggie Donius, RN, Oregon Nursing Association
- Kurt Duffens, MD, St. Vincent Hospital
- Patrick Dunn, MD, Chair, Legacy Good Samaritan Hospital
- Ted Falk, JD, Oregon Health Decisions
- Dan Field, JD, Oregon Association of Hospitals
- Marshall Goldberg, MD, Kaiser Permanente
- Schuyler Hoss, Oregon Assoication for Home Care
- Joanne Hoyt, Washington County EMS
- Ann Jackson, MBA, Oregon Hospice Association
- Kathy Kato, Holladay Park Hospital
- Howard "Skip" Kirkwood, Oregon State EMS
- Gail Madsen, Oregon State EMS
- Dan McFarling, Senior & Disabled Services Division
- Jody Ann Noon, JD, Oregon Association of Homes for the Aging
- Roy Payne, MD, Oregon Medical Association
- Brenda Quint-Gaebel, Health Information Management Association
- Nancy Sayan, Oregon Medical Assistance Programs
- Trudy Schidleman, RN, Multnomah County EMS
- Terri Schmidt, MD, Emergency Services, OHSU
- Kathleen Smail, RN, Oregon State Health Division
- Susan Tolle, MD, Treasurer, Center for Ethics in Health Care, OHSU
- Molly Weinstein, JD, Senior & Disabled Services Division

The coalition was designed to assure key stakeholder representation while partnering with strong physician champions in EMS, academic medicine and within health systems. The Task Force recognized the need to clarify the distinction between advance directives and medical orders and changed the document name to “Physician Orders for Life-Sustaining Treatment” or “POLST.” A major focus in these early years of the new ‘POLST Task Force’ was to address statutory and regulatory barriers to effective POLST implementation across all settings of care.

Since 1992, the Task Force has continued to meet regularly. Initial meetings were held at Legacy Good Samaritan Hospital with a high level of support by the Chief of Medicine; Dr. Stephen R. Jones. Task Force gatherings moved to the OHSU campus in 2007 and continue to address ongoing education, policy development, and research with a focus on continuous quality improvement.

The Oregon POLST Task Force members in 2000, front row (left to right): Susan Tolle, MD (Treasurer, OHSU), Trudy Schidleman, RN (Multnomah County EMS), Patrick Dunn, MD (Chair, Legacy Good Samaritan Hospital and OHSU), Terri Schmidt, MD (OHSU). Back row (left to right): Mark Bonanno, JD (Oregon Health Decisions), Ann Jackson, MBA, (Oregon Hospice Association), Dan McFarling (Senior & Disabled Services Division), Tim Hennigan, EMT-P, Jerry Andrews, EMT-P, (Oregon Health Div.), Chris Nelson, RN (OHSU), Dan Field, JD, (Oregon Association of Hospitals and Health Systems), Holly Robinson, JD, (Senior & Disabled Services Division) and Anne-Marie Jones (OHSU).

1993: Oregon's New Advance Directive Statute Includes Treatment Preferences and Health Care Representative

In 1978, Oregon passed its first advance directive statute known as the "Directive to Physicians." The directive was relatively narrow in scope, addressing a person's wishes regarding cardiopulmonary resuscitation (CPR) should there be a complete cessation of heart and lung function. Recognizing the limited clinical utility, the Oregon legislature passed the current advance directive statute in 1993. The directive now includes a person's specific instructions about "life support" and "tube feedings" in each of four scenarios: close to death, permanently unconscious, advanced progressive illness and extraordinary suffering. The document was a major improvement in eliciting and recording a person's values regarding life-sustaining treatments.

To honor the wishes of the very seriously ill, clinicians still needed a person's values translated into actionable medical orders. The nascent Medical Treatment Coversheet and later POLST (including orders about CPR, ventilator use and tube feedings), became effective methods to help honor a seriously ill person's wishes as expressed in the new advance directive. With these improved tools, health care professionals could translate their patient's treatment preferences into medical orders, changing the way medicine was practiced. For example, use of tube feedings for those with advanced progressive illness became a more thoughtful consideration with a patient and loved ones. By the year 2000, in response to cautious discernment of growing data that feeding tubes did not extend life in this population, 2000, permanent feeding tube use dropped to near zero in Oregonian's with advanced dementia.

1993: Early Development and Evaluation of the Oregon POLST Program

The original form, known as the Medical Treatment Coversheet (MTC), included a set of portable standard medical orders regarding life-sustaining treatments based on a patient's preferences including those in their advance directive. The Task Force and OHSU's Center for Ethics worked with Oregon legislators to strengthen the advance directive statute to help patients and families express their values about future life-sustaining treatment use including artificially administered feedings by tube. Rather than such treatments being routinely applied, patients now were better empowered to determine which treatments they wanted if they became seriously ill. The MTC reflected this empowerment, having medical orders for various life-sustaining treatments, including Section D about tube feedings.

Medical Treatment Coversheet (first version that later became the POLST form, click on form to enlarge).

The MTC was refined with focus group feedback from clinicians caring for patients in acute and long-term care settings. The name was changed to “Physician Orders for Life-Sustaining Treatment (POLST)” to distinguish the medical order form more clearly from a traditional advance directive. The following organizations endorsed the MTC for voluntary use:

- Center for Ethics in Health Care, OHSU
- Multnomah County Medical Society
- Oregon Association of Homes for the Aging
- Oregon Association of Hospitals
- Oregon Chapter, American College of Emergency Physicians
- Oregon Health Care Association
- Oregon Health Decisions
- Oregon Hospice Association
- Oregon Long Term Care Nurses Association
- Oregon Society of Physician Assistants
- Oregon State Ambulance Association

1993: The Vital Role of Statewide Education

The Task Force recognized early on that education is the key to effective use of the Medical Treatment Coversheet (MTC, and later POLST) form. For the program to succeed statewide, health care professionals received updates on form use, newly developed policies and advances in research. The Task Force developed numerous educational resources and relied on member organizations to develop effective on going learning for their constituents. In essence, the group became a clearinghouse of information and the sharing of ideas, catalyzing resource development, all to help health care organizations educate their member health care professionals. Here are some examples of these early educational tools:

- Pamphlets including the MTC form and a step by step implementation process
- Videotape explaining how the MTC is used and implemented
- Consultation with health care professionals skilled in the use of the form
- Executive summary of the MTC evaluation project

- Initial “Train the Trainer” conference providing education about Oregon’s new advance directive statute (including decisions for a patient to have or forego permanent feeding tube placement)

The Task Force recognized that education is a cornerstone of the POLST Program. Click here for a more extensive archive of early educational resources for health care professionals, health care systems and patients and families.

1994: EMS Education Prior to Statewide Dissemination of POLST

Dr. Terri Schmidt, an emergency medicine physician and a county EMS medical director, along with Jerry Andrews EMT-P and other EMS professionals helped assure that POLST development and implementation was designed in ways that could be honored by EMS providers and emergency medicine physicians statewide. The initial form, developed by a Oregon ethics leaders, EMS, and all of the member stakeholders was modified with EMS fully engaged as partners in every step of the revision process. Prior to clinical use first responders were given clinical scenarios to assure orders would never result in under treatment (see annotation of Journal of the American Geriatrics Society, 1996;44, 785-791). Once this pilot testing was complete and prior to statewide dissemination of the Oregon POLST Program, Dr. Schmidt led an intensive EMS educational effort. As with other professional groups, EMS education has been and needs to be supplemented with additional yearly instruction.

Dr. Terri Schmidt led an intensive EMS education effort.

1995: Oregon POLST Release

Guided by evaluation findings, the Task Force released a slightly revised version of the POLST form for use throughout Oregon. The Task Force used data from research and employed a continuous quality improvement method to actively elicit feedback from clinicians and patients and families using the form. For example, a prospective one-year study of POLST form use in eight nursing homes demonstrated effectiveness; no resident with orders for Comfort Measures Only and DNR received CPR, ventilator support or ICU care (see annotation of Journal of the American Geriatrics Society, 1998;46, (9), 1097-1102).

1995 version showing the front and back of the Oregon POLST form (click on the form to enlarge).

1999: EMT/First Responder Scope of Practice Change

For the POLST form to be effective, emergency personnel wanted further protection from liability when honoring POLST orders. To address this, the Task Force recommended a change in the Oregon Medical Board's administrative rules defining the Scope of Practice for EMT's/First Responders (OAR 847-035-0030). The Board approved language states:

An Oregon-certified First Responder or EMT, acting through standing orders, shall respect the patient's wishes including life-sustaining treatments. Physician supervised First Responders and EMTs shall request and honor life-sustaining treatment orders executed by a physician, nurse practitioner or physician assistant* if available. A patient with life-sustaining treatment orders always requires respect, comfort and hygienic care.

*Nurse practitioners and physician assistants were added as signers in 2001 and 2007 respectively.

2001: Minors Included

Community clinicians requested the Task Force to consider use of the POLST form for children with terminal illness. A community and task force consensus process included focus group input from various professionals and health care organizations that care for children and from the school system. The Oregon POLST Task Force modified the program to include minors and recognized parents as the surrogate for their terminally ill child, consistent with Oregon law.

2001: Nurse Practitioner Included as Signers

Nurse practitioners (NPs) provide primary care for a substantial number of Oregonians. In the early years of the program POLST forms for NP patients needed to be signed by a supervising physician even though these orders were similar to other NP orders not requiring this signature. The Task Force worked with the Oregon Board of Nurses in determining that POLST orders are within the scope of practice for NP's and therefore do not require physician co-signature. Emergency Medical Service (EMS) responders were not allowed to take orders from nurses so the Task Force worked with EMS to ensure that POLST orders signed by an NP could be followed by EMS based on their standing orders from their EMS supervising physician.

2004: Center for Ethics Convenes National POLST Paradigm Task Force

Other states began expressing interest in Oregon's pioneering POLST experience. Convened under the leadership of Dr. Patrick Dunn and with administrative support from the OHSU Center for Ethics, regular phone meetings of the POLST leaders from the six most advanced POLST Paradigm states began in 2004. The thirteen founding members of the National POLST Paradigm Task (NPPTF) Force were Patrick Dunn, MD, Chair (OR) and Susan Tolle, MD, Treasurer (OR), Bud Hammes, PhD (WI), Woody Moss, MD (WV), James Shaw, MD (WA), Sally Denton (WA), Judy Black, MD (PA), and Patricia Bomba, MD (NY) with

advisors Terri Schmidt, MD (EMS), Margaret Carley, JD (Long-term Care), Susan Hickman, PhD (Research), Charles Sabatino, JD (Legal), and Malene Davis (Hospice).

First face-to-face meeting of the National POLST Paradigm Task Force in New Orleans, 2007. (Not pictured: Sally Denton, Malene Davis)

Judy Black, MD

Margaret Carley, JD

The initial criteria for state inclusion in the NPPTF was a minimum of three years' experience using the POLST Paradigm at the regional or statewide level. In 2004, only six states met this requirement: OR, WA, WI, PA, NY and WV.

In 2004, the Oregon POLST Program was the most mature program with longest history and had the strongest research program, the most EMS experience and the highest level of penetration in long-term care. As a result, the composition of the initial thirteen Founding NPPTF included five members from Oregon.

Dr. Susan Tolle led funding efforts for the NPPTF from inception to 2015. The NPPTF adopted the same standards of accepting private donations and grants only, and not accepting funding from health care industry sources (NPPTF conflicts of interest policy). By mutual agreement the NPPTF could not accept health care industry support as long as they were part of the Center for Ethics. Effective January 20, 2017, the NPPTF became independent of the OHSU Center for Ethics and approved a change in its funding policy, allowing support from health care industry sources. As of March 2017, the differences in NPPTF and Center for Ethics policies are being considered by the Oregon POLST Task Force and the Center.

2005: POLST presented to the White House Conference on Aging (WHCOA)

In 2005, Drs. Judy Black and Susan Tolle presented on behalf of the National POLST Paradigm Task Force to the White House Conference on Aging (WHCOA): Care Coordination Across the Continuum.

2007: POLST Orders Honored in All Oregon Acute Care Facilities and Physician Assistants Included as Signers

In 2006, some emergency physicians and health care systems raised concerns about following POLST orders signed by a health care professional who was not on their medical staff. In order to clarify this issue, the Task Force worked with the Oregon Medical Board (OMB) to establish new administrative

rules. In addition, leaders in the PA professional community requested that PAs be considered as signers of POLST orders. In 2007, the Board included PAs in rule changes regarding respecting orders for life-sustaining treatment in all Oregon health care facilities. OAR 847-010-0110 states:

- (1) A physician or physician assistant licensed pursuant to ORS Chapter 677 shall respect the patient's wishes including life-sustaining treatments. Consistent with the requirements of ORS Chapter 127, a physician or physician assistant shall respect and honor life-sustaining treatment orders executed by a physician, physician assistant or nurse practitioner. The fact that a physician, physician assistant or nurse practitioner who executed a life-sustaining treatment order does not have admitting privileges at a hospital or health care facility where the patient is being treated does not remove the obligation under this section to honor the order. In keeping with ORS Chapter 127, a physician or physician assistant shall not be subject to criminal prosecution, civil liability or professional discipline.
- (2) Should new information on the health of the patient become available the goals of treatment may change. Following discussion with the patient, or if incapable their surrogate, new orders regarding life-sustaining treatment should be written, dated and signed.

2008: POLST and Persons with Disabilities

The Oregon POLST task force convened health care and disability leaders to clarify how POLST should be used for persons with disabilities, specifically Intellectual/Developmental Disabilities. The goal of this collaboration was twofold, to:

1) Assure that persons with disabilities who are nearing the end of life receive high quality care, and

2) Prevent the use of POLST in those persons with stable disabilities who lack life threatening conditions.

Since that time, the guidebook has been rewritten to reflect ever changing aspects within Oregon law.

2009: Oregon POLST Registry

Although by this time, POLST was the accepted standard for communicating patient preferences surrounding life-sustaining treatment, EMS responders reported frequently that the POLST form could not be found in the first few minutes that they were on scene (The Oregon POLST Registry: A Preliminary Study of Emergency Medical Services Utilization). A pilot project was funded by private philanthropy including a grant from *The Greenwall Foundation* and gifts from individual donors with the goal of enhancing POLST form access.

The first phase of the project consisted of designing the electronic Registry. In January 2009, the second phase began, with system training and testing of the developed Registry by the project team, with the OHSU Emergency Communications Center and EMS professionals in Clackamas County. May 2009 marked the roll out of the third phase or “pilot” of the Oregon POLST Registry with initiation in Clackamas County on May 26, 2009.

Concurrently, Task Force leaders worked to facilitate legislation to create and fund the Oregon POLST Registry, which would be "owned" by the Oregon Health Authority but operated under contract by the OHSU Department of Emergency Medicine. The legislation addressed HIPAA requirements, mandated that health care professional signers (or their designees) submit forms unless the patient opted out and provided funding for the Registry. All other aspects of the POLST Program including form revision remained under the leadership of the Oregon POLST Task Force administered by the OHSU Center for Ethics. The legislation became law on July 1, 2009 and the Registry office began accepting forms from all of Oregon. On December 3, 2009 the Oregon POLST Registry was implemented statewide. For further details of POLST Registry development visit the Oregon POLST Registry website at www.orpolstregistry.org.

2010: Trademark Registration

The Center for Ethics recognized the need to protect the identity of the POLST Program because of some well-meaning groups that wanted to emulate POLST yet were not meeting the rigorous standards initially developed by the Oregon POLST Program. The concern was centered on the quality of programs and their care of patients and not concerns for any proprietary protection. The Center for Ethics in Health Care at OHSU, the initial administrative home for the National POLST Paradigm Task Force, successfully received approval and OHSU still holds three trademarks related to its efforts: "POLST," "POLST Paradigm," and the program's visual graphic of the "O" in POLST.

2010: Leadership and Succession Planning

The Oregon POLST Task Force recognized the need to encourage participation by leaders from various health care professions. Physician, EMS, nurse and legal leadership are essential and Oregon has been fortunate to have strong representation from each of these disciplines. The timeline below lists the dates of service of each of the Chairs of the Oregon POLST Task Force.

In addition, the Oregon POLST Task Force required the dedication and administrative expertise of its program coordinators. These talented individuals were supported by the Center for Ethics in Health Care at OHSU, keeping the Task Force organized with its myriad projects. The position has grown from part-time to now full time given the growth in the responsibilities of the coordinating position.

Program Coordinators: Anne-Marie Jones, Jane Ayotte, Andrea Sardella, Lalita Hamm, Sarah Foreman Papp, Bill Pfunder, Faith English, and Valerie Jimenez.

As with any organization, succession planning is essential. Recognizing this, the Task Force has continually nurtured strong representation by its member organizations and cultivates participants for leadership roles.

2011: Sustainability and Avoiding Conflicts of Interests

Early on, the Oregon POLST Task Force and subsequently the National POLST Paradigm Task Force (NPPTF) recognized the promises and perils of various funding sources. Accepting support from private

donations and grants limits the ability to raise much needed funds. Broadening potential funding to include health care industry sources would have been in some ways easier, yet increased the risk of conflicts of interest. For example, if funding was accepted from a well-meaning insurance company, the public might perceive that the program's primary goal was to save health care dollars by encouraging the limitation of treatments. To ensure that any actual, potential or perceived conflicts of interest were either avoided or managed, in 2009, the NPPTF adopted a policy similar to OHSU's Center for Ethics' policy, the administrator of the Oregon POLST Program.

2011: Antibiotic Section Removed Because of Limited Impact

Since Oregon created the first POLST form, that form served as a model for all other states. Initial versions of the Oregon POLST form included four sections addressing preferences forCPR, Scope of Treatment, Antibiotics and Artificially Administered Nutrition. The Oregon POLST Task Force pursued research data to inform each step of the form's revision process. Early data confirmed that orders in Section A (CPR/DNR) and Section B (Scope of Treatment) were highly correlated with the level of treatments patients received.

A three state (OR, WV, WI) 90 nursing home study led by Susan Hickman Ph.D., was the first study to examine the degree to which orders related to antibiotic use were honored (see annotation of Journal of the American Geriatrics Society, 2011; 59(11):2091-2099). In a 60 day period about one third of residents of skilled nursing facilities received antibiotics. The rate was the same irrespective of the order to administer or forgo antibiotic use suggesting that orders in the antibiotic section had little impact on the treatment patients ultimately received.

Once a state POLST Program is in wide spread use, making major revisions to the form is difficult. After years of debate, this new data led the Oregon POLST Task Force to remove the separate antibiotic section in 2011 and incorporate the use of antibiotics under 'Scope of Treatment' in Section B.

The Task Force was aware of these results several years prior to publication of this study and shared the findings with colleagues in developing states. As a result several states did not include a separate antibiotic section in the first version of their state's POLST form.

2014: Research Guides POLST Education, Policy and Implementation

A cornerstone of POLST Paradigm research, seeks answers to help develop sound policy, and identify the most effective methods in education and implementation. In short, the program seeks truth, always aiming to improve the care of those served. For more information on the growing list of research publications, please see our publications section in the Professional Resource Library.

2015: ePOLST Technology

As electronic medical records became the norm, many groups expressed interest in developing electronic versions of POLST. Providence Health and Services in Oregon worked with the POLST Task Force to create a pilot and was the first to develop an electronic POLST completion system. They used an

EPIC Smart Form. Providence worked closely with the Oregon POLST Registry to create a secure electronic submission system.

In April of 2015, OHSU developed a partnership with the Vynca ePOLST system which provides an electronic completion system accessed within Epic with direct submission to the Oregon POLST Registry. To ensure that POLST orders can be accessed with a single click, the "ePOLST Yes/No" tab was included on the patient header (Oregon POLST policy recommendation). The system was designed to facilitate bidirectional communication with the Oregon POLST Registry.

2016: National POLST Honors Oregon's Service

The "Flame of Excellence" was presented to Dr. Susan Tolle at the 2016 national POLST conference to honor Oregon's outstanding service in support of the National POLST Paradigm. Four Oregon leaders have made major contributions to the national advancement of the POLST Paradigm by serving as consultants to other states.

2016: Ongoing Education, Policy Development and Research

The POLST Paradigm, as with all worthwhile endeavors, can improve only if it embraces thoughtful input. Some critical of the Paradigm, believe withholding or withdrawing life-sustaining treatments is the primary goal. This is not at all the intent. Instead, the Paradigm seeks to ensure that a patient's preferences are honored, whether a patient wants all treatments or desires to limit specific treatments. The POLST Paradigm asks "How can we together best ensure that a patient's treatment preferences are respected?" "If there are concerns about the POLST Paradigm, what suggestions might make things better?" The path to achieving these goals is by inviting all interested parties to contribute their ideas whether they agree *or not* with the current status of the Paradigm.

As an example, the Task Force learned about some circumstances in which POLST use could be improved. So, the Oregon POLST Task Force produced a 2015 cautionary video, "The POLST: Doing It Better," to promote high quality use of the POLST Paradigm. Welcoming feedback, improving education and policy, and conducting research and quality assurance; all embody the POLST Paradigm endeavor. It is with this enduring spirit that Task Force members hope to continue to improve the care of those served.

2016: Strengthening Community Voice

The Oregon POLST Program added a new committee to expand direct representation of members of the lay public. The Oregon POLST Task Force continues to have members representing AARP and Oregon Health Decisions. In addition to public advocacy group representation, in February 2016 the Community Insight Committee was created adding greater diversity and a more direct pathway for collaboration with community members.

2017: Oregon POLST Task Force Changes Its Name

Effective March 2017, the Oregon POLST Task Force changed its name to the Oregon POLST Coalition, recognizing that we are here to stay. After more than 25 years of development and service, members decided its name should reflect its intended permanent commitment. The group has been successful in its mission to develop a new method to translate patient preferences into actionable medical orders that follow patients across settings of care. The Coalition will continue to strengthen POLST education, technology, quality improvement, community involvement, and innovative research.

2017: Oregon POLST Coalition Reaffirms Values Avoiding Conflicts of Interest

In June 2017, the Oregon POLST Coalition reaffirmed its foundational values of not accepting support from the health care industry. Actions include: 1) clarifying the Center for Ethics policy on conflicts of interest (a policy that the Coalition honors as the Center serves as its administrative home) and 2) withdrawing membership from the National POLST Paradigm Task Force (NPPTF) because of its 2017 policy change to accept health care industry funding. The Oregon POLST Coalition trademark is changed to reflect this change in relationship with NPPTF.

To preserve public trust and the program integrity, it is essential that Oregon POLST accept support only from non-health care industry sources. To accept health care industry funding could imply a conflict between the Oregon POLST Program goal to honor patient choice and possible cost saving that would benefit industry. Center policy does not allow funding from commercial health care related entities including, but not limited to, insurance companies, pharmaceutical manufacturers, device makers and other health care product suppliers. The policy also does not allow Center leaders to have associations with health care industry.

The Coalition will continue to collaborate with NPPTF colleagues as supported by Center policy.

Source: National POLST Paradigm. (2018). POLST program designations. Retrieved from http://polst.org/programs-in-your-state/?pro=1

2017: Sustainability: Improving End-Of-Life Care Now and Long into the Future

The OHSU Center for Ethics in Health Care serves as the organizational home of the Oregon POLST Program (and between inception in 2004 and January 20, 2017 also served as the home of the National POLST Paradigm). Center leaders have dedicated substantial time to grant writing, fundraising and administrative support while always staying true to the Center's commitment to not accept funding from health care industry sources. Health care professionals and community members have donated tens of thousands of hours of volunteer time creating, revising and disseminating the POLST program; guiding policy development, facilitating health care systems change, developing and disseminating educational materials, investing in research and working on overall POLST program quality improvements. As of 2017, the Oregon POLST Program is using the 11th version of the Oregon POLST form.

Securing funding to lead new innovation and sustain the Oregon POLST Program efforts has been and remains a priority of the OHSU Center for Ethics. It is with gratitude that the Center acknowledges grant support from the following foundations:

Archstone Foundation

California HealthCare Foundation

The Alyce R. Cheatham Family Fund of the Oregon Community Foundation

The Collins Foundation

Collins Medical Trust

The Nathan Cummings Foundation

The Arthur Vining Davis Foundations

The Denison Family Fund of the Oregon Community Foundation

The Greenwall Foundation

Robert Wood Johnson Foundation

Samuel S. Johnson Foundation

The Kinsman Foundation

The Gilbert J. Martin Foundation

The Retirement Research Foundation

Don & Joan Strand Foundation at FCGF

Gifts from private individuals play a vital role in funding program innovation and building an endowment that will permanently sustain the Oregon POLST Program. We gratefully acknowledge **Bill and Karen Early** for their contribution of $1 million to launch the endowment fund with a $4 million goal. We are thankful also to all of the individuals who have and continue to support the POLST program. Several of these individual donors requested that they be acknowledged anonymously on this website. To each donor who has given please know that your impact has been very great. To date about 1 million patients and their families across the country have suffered less and more frequently had their wishes for treatment near the end of their lives honored because of your generosity.

While the Oregon POLST Program has made many advances and addressed many important systems problems, new challenges continue to arise. Health care is changing and the need for education, policy improvements and research never end. With sustainable support the Oregon POLST Program can better respond to these challenges now and long into the future.

2018: Oregon Statute Authorizes ND Signers

The Oregon Legislature (2017 SB 856) expanded the scope of practice of naturopathic doctors (NDs) to include the ability to sign POLST forms effective January 2, 2018. Of the 46,188 POLST forms entered into the Oregon POLST Registry in 2018, 56 (0.12%) forms were completed by 14 NDs (range 1 to 37).

2019: POLST Form Name Changed to be More Inclusive

When POLST was originally established only physicians (M.D. and D.O.) could sign POLST orders. In 2018, the Oregon POLST Coalition recognized that using the word "physician" in the description of POLST was not inclusive of all disciplines currently authorized to sign POLST orders. Effective January 2, 2019, the Oregon POLST form was changed to "Oregon POLST® Portable Orders for Life-Sustaining Treatment."

2019: POLST No Longer a Solid Pink Form

To improve the quality of readability on faxed and photocopied POLST forms, the Oregon POLST Coalition voted to no longer produce a solid pink POLST form. Effective January 2, 2019, the Oregon POLST form became a black and white form with a pink border.

2019 Oregon POLST Form

2019: Artificially Administered Nutrition Removed from POLST Form

The artificially administered nutrition 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"). After careful review of quality data, the Oregon POLST Coalition voted to remove the artificially administered nutrition section from the Oregon POLST form.

On January 2, 2019, Oregon became the first state to remove artificially administered nutrition from its POLST form (*J Am Geriatr Soc*. 2019 Jan 31, https://doi.org/10.1111/jgs.15775). Click here to learn more by listening to the GeriPal Podcast, "Time to Remove Feeding Tubes from POLST."

2019: Guidelines for Persons with Significant Disabilities - Updated from 2008

The Oregon POLST Coalition received significant contributions from the Oregon Department of Human Services to update guidelines of POLST use for persons with significant disabilities, specifically Intellectual/Developmental Disabilities, who are nearing the end of life.

The guidelines first outlined in 2008 have been rewritten to reflect ever changing aspects within Oregon law. To view the most current **Guidelines on POLST Use for Persons with Significant Disabilities who are Now Near the End of Life**, click HERE.