

POLST

New Challenges and Opportunities
in a Changing Health Care Landscape



WELCOME

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LEARNING OBJECTIVES

- Differentiate between DNR status and Selective or Comfort Measures orders. Describe the full range of medical interventions that should continue to be provided based on patient goals of care.
- Describe appropriate use of POLST, including settings when not to use POLST.
- Understand the importance of conversations with loved ones in individuals who are completing a new POLST or have a POLST on record.
- Explain the ethical and legal foundations for involving a support person during conversations that could result in the decision to set limits to the treatments provided.
- Document conversations about POLST transparently to reflect ethical deliberation, legal compliance, and respect for patient dignity.

“

**OH, NEVER MIND. THE PATIENT IS DNR.
WE SHOULD JUST KEEP HER
COMFORTABLE.**

”

DNR DOES NOT MEAN “DO NOT TREAT”

- Ethical obligation to address the conflation of DNR status with “Comfort Measures Only” status
- Rather than one set “elevator speech,” it is appropriate to adapt the conversation to the circumstances and the individual
- Can help to start by asking someone to describe their thinking process
- There are medical situations where an individual would not want CPR but would want all other available treatments; having case examples can help
- Remain grounded in eliciting and honoring patients’ treatment preferences

“An Advance Directive is burdensome to complete. POLST is a better way to ‘get credit’ for Advance Care Planning work.”

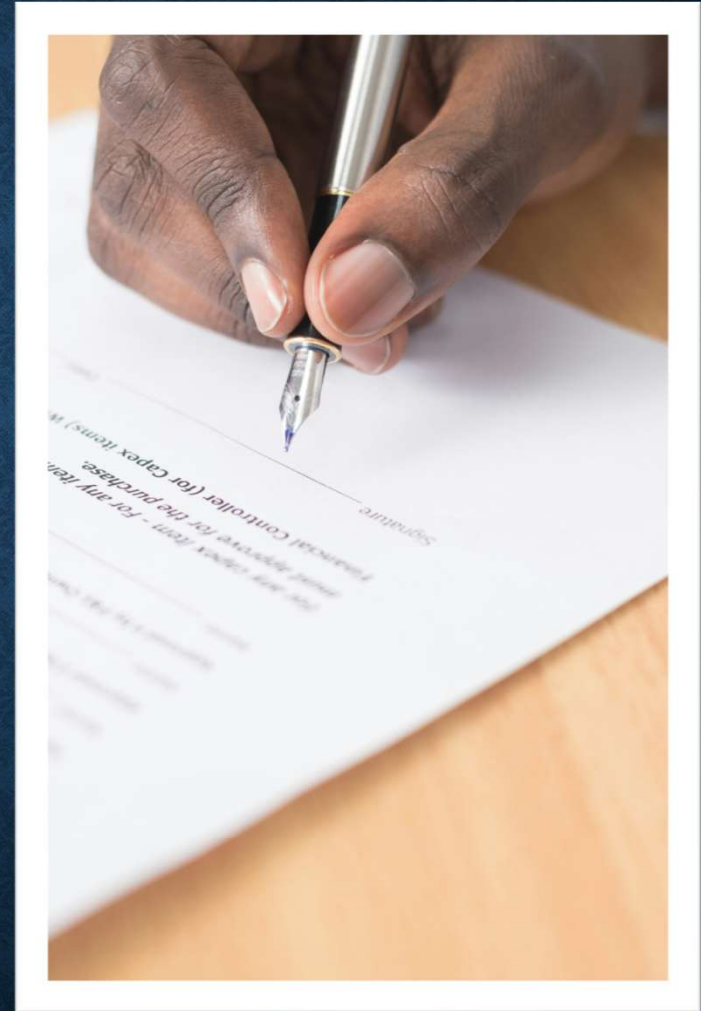


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QUALITY IMPROVEMENT

- NQF 0326 “Advance Care Plan”
- Denominator = all patients 65 years and older.
 - Applies to qualifying visits in all care setting except the ED.
 - Individuals receiving hospice care are excluded.
- Numerator = Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

OPPORTUNITIES FOR MEETING ADVANCE CARE PLANNING QUALITY METRICS

- The NQF metric appropriately emphasizes ACP **conversations rather than completion of forms**
- The challenge is often how to measure/report that these conversations have occurred
- Documenting surrogate decision maker is both clinically meaningful and can often be tracked/measured in the EHR
- Developing standards for how and where to put ACP conversations in the chart is clinically meaningful for patients and would improve ability to “get credit” for these important conversations



**DANGER OF
USING POLST
AS A
COST-SAVING
MEASURE**

MISPERCEPTION THAT POLST IS REQUIRED IN LONG TERM CARE SETTING



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- **POLST** (Portable Orders for Life-Sustaining Treatment) is **always voluntary** and **cannot be required** as a condition to receive care or transportation or reside in a long-term care facility. *ORS 127.672*
- The best practice is to use a facility order to indicate a resident's code status.
- Full Code POLSTs should not be routinely created as Full Code is the care automatically provided.
- An Advance Directive is more appropriate for Full Code residents. An Advance Directive allows residents to document their health care goals, values, and wishes. In addition, an Advance Directive allows individuals to appoint a health care representative to communicate their wishes for care when the individual cannot make such decisions for themselves.
- If a person has decided that they do **not** want to receive CPR if their heart stopped now in their current state of health, then we recommend that person be offered a DNR (Do Not Resuscitate) POLST to set limits for their emergency care.
- A DNR POLST does **not** mean, "Do not treat" or "Do not hospitalize." Please refer to Section B in a resident's POLST for information about individualized treatment preferences.

Role of POLST for residents being transported out of facility

- A POLST is not required for transport. Paramedics and ambulance teams will ask if a resident has a POLST so they can honor a resident's wishes that would be other than Full Code.
- If a resident does not want to receive CPR, that person should be offered a DNR POLST. In the absence of a DNR POLST, paramedics and ambulance teams must provide CPR.

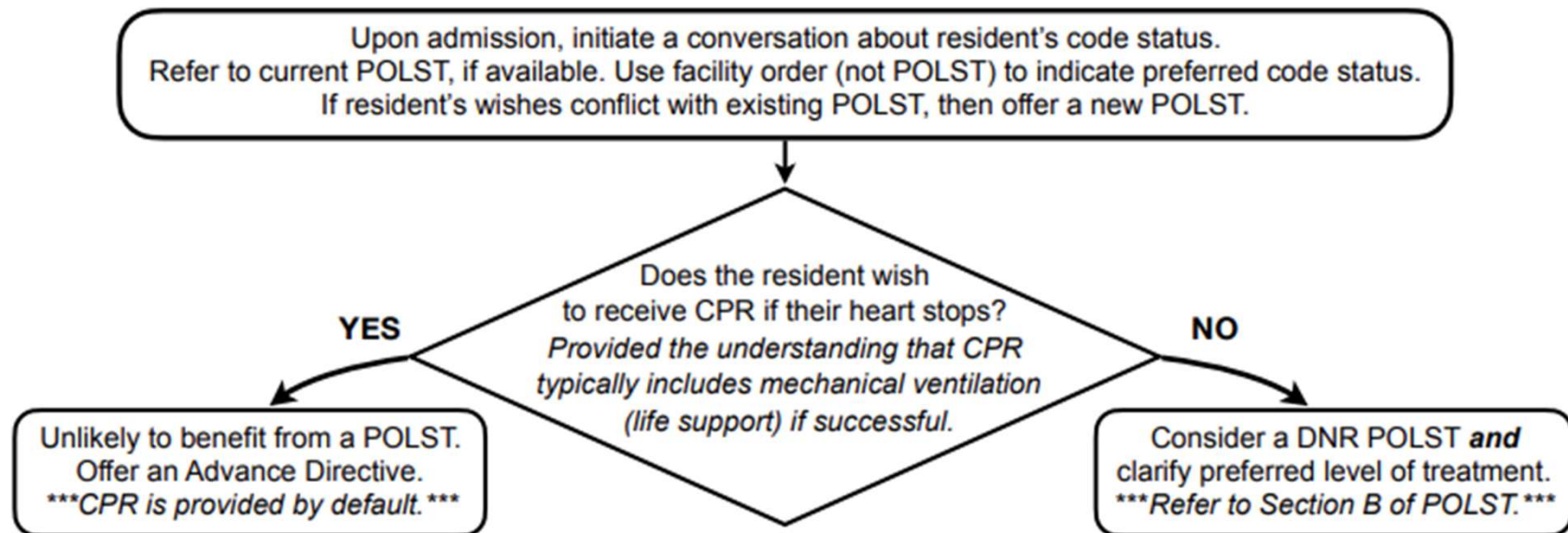
See other side for important information.



OREGON DEPARTMENT OF
Human Services

A cooperative project of
ODHS Safety, Oversight and Quality
and the Oregon POLST Program

OREGON
POLST
PORTABLE ORDERS FOR LIFE-SUSTAINING TREATMENT®



Advance Directive	POLST
Legal document that states preferences for treatment. EMS cannot follow (because not medical orders).	Medical orders that immediately take effect. EMS can follow these medical orders.
Must be offered to all nursing facility residents. Always voluntary to complete.	Not relevant for all residents. Always voluntary to complete.
Appoints a health care representative.	Does not appoint a health care representative.
Helpful to all adults, as it provides guidance for future health care treatments.	Most helpful to individuals with serious illness who wish to set limits to emergency treatments.

MANY CONVERSATIONS ABOUT POLST WILL NOT RESULT IN THE CREATION OF A POLST.

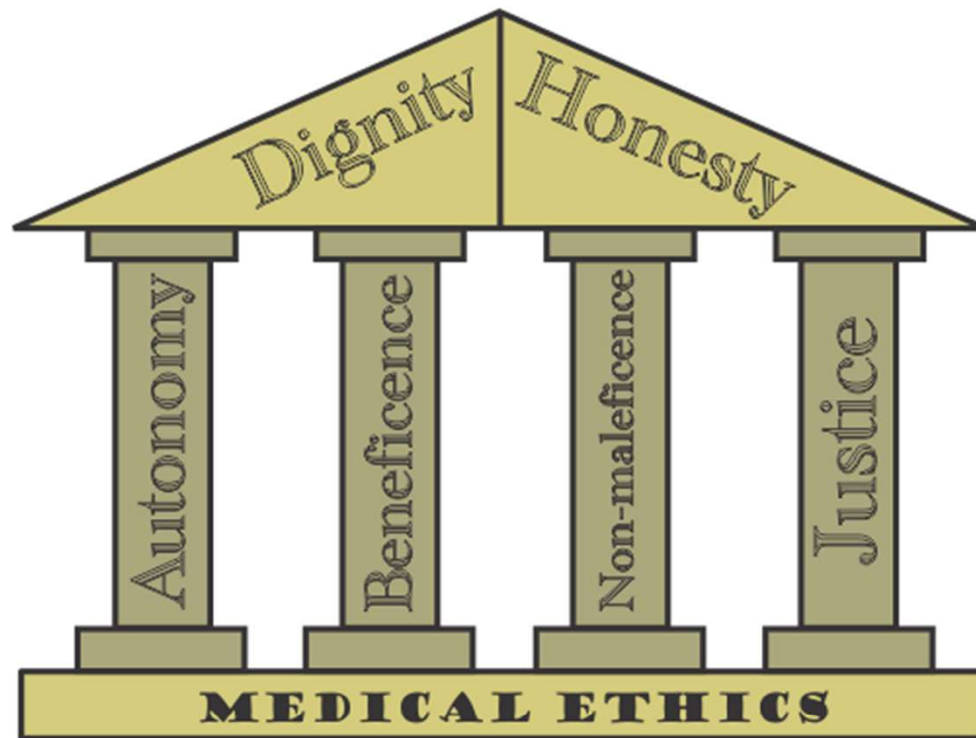
- Most Full Code/Full Treatment patients do not need a POLST
- What documentation should be done and where should that information “live” in the EHR?



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C <i>Check All That Apply</i>	DISCUSSED WITH: (REQUIRED)		
	<input type="checkbox"/> Patient	<input type="checkbox"/> Parent of minor	<input type="checkbox"/> Relative, friend or other support person (without written appointment) - See reverse side for additional requirements for completion in persons with intellectual or developmental disabilities.
	<input type="checkbox"/> Person appointed on advance directive		
	<input type="checkbox"/> Court-appointed guardian		
	List all names and relationship: _____		

- Why is section C important?
- What is the difference between a healthcare representative and a support person?



Six Values in Medical Ethics, illustrated by Klimes Institute

Portable Orders for Life-Sustaining Treatment (POLST®):
Guidelines on POLST Use for Persons with Significant Disabilities
who are Now Near the End of Life

(Revised 01.23.2025)

The **Mission of the Oregon POLST® Coalition**¹ is to improve the quality of life for Oregonians nearing the end of life by providing an evidence-based, patient-centered, voluntary process that elicits, records and honors the treatment goals of those with advanced illness and frailty in a compassionate manner that is respectful of the inherent dignity of the individual.

Appropriate Use of POLST for Persons with Intellectual/Developmental Disabilities

The **Portable Orders for Life-Sustaining Treatment (POLST)** Program was initiated in Oregon in the early 1990s to ensure patients' preferences for end-of life-care are honored across various care settings.² The POLST form transforms a patient's treatment plan and goals of care into a medical order. Emergency medical responders and emergency medicine health care professionals follow these orders unless there is new information from the patient or health care representative.³

When serving Oregonians with Intellectual or Developmental Disabilities (IDD), it is essential that fundamental safeguards be maintained in POLST use. The purpose of this document is to raise awareness of the appropriate use of POLST and specifically to **advise against** the use of POLST in **those with stable disabilities who do not have a serious illness that is in the advanced stages.**

COMMUNICATING POLST DECISIONS WITH LOVED ONES



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TAKE HOMES

- DNR ≠ Do Not Treat
- It is legally required (and ethically the right thing to do!) to offer a support person to an individual with intellectual or developmental disability when having a conversation that could result in a decision to limit treatments.
- Encourage conversations with family/loved ones when a POLST is created.
- Avoid overuse of POLST
 - To “count” for quality improvement
 - As a cost-saving measure
 - To document code status in LTC settings
 - As a way to document a conversation about goals of care

Thank you!

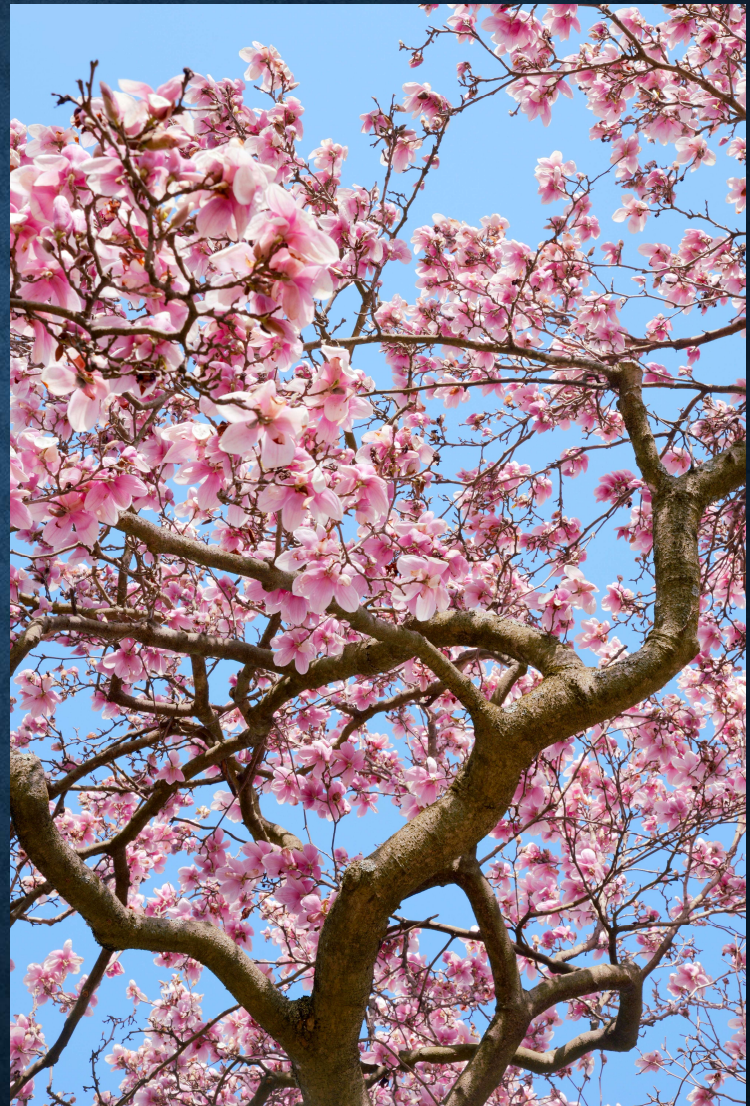


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