Advance Directives and POLSTs

*…considering **your** options for healthcare … near/at the **end of life***

John Forsyth, M.D. Retired Cardiologist
Mended Hearts Monthly Colloquium
April 19, 2022

My Perspective …

- *My career in medicine/cardiology* (1961-present)
- - parallels "greatest expansion" knowledge & tech (?***64* x**);

- - *incredible benefits* for *many* pts, especially in mid-life:
- … improved both *quantity* and *quality* of life/health/fx;

- - nonetheless, since 1990, *two notable consequences*:
- a) *spiraling costs*;
- → b) *poor* ***quality*** *of care near/at end of life.*
- *(→ resurgence of* ***hospice*** *&* ***palliative*** *care)*
- (~10% → ~60% of deaths)

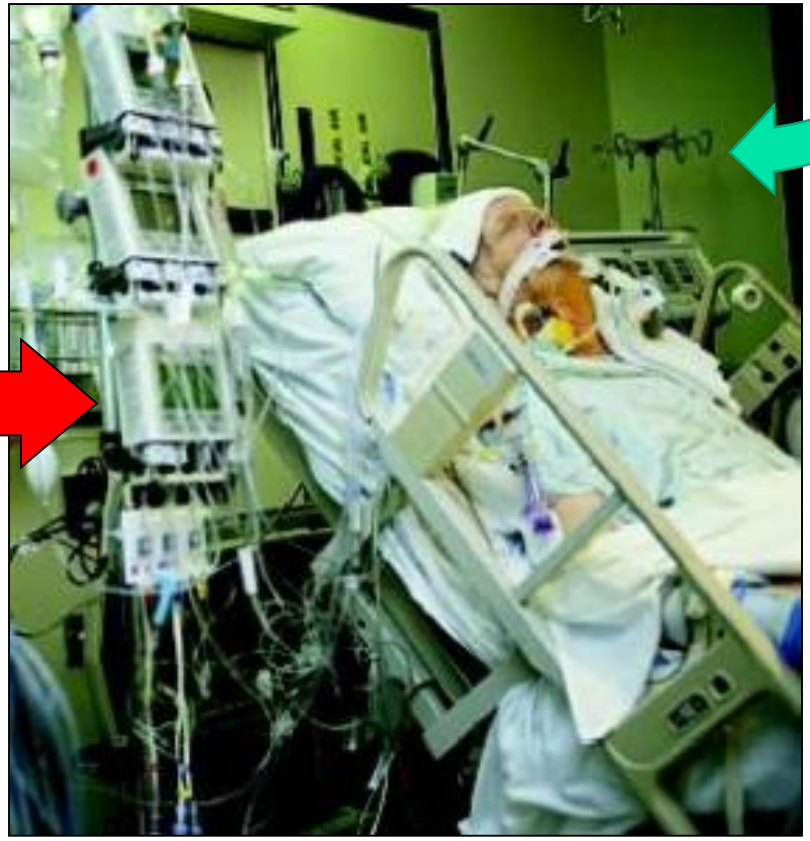
The End-of-Life Care Paradox:

Most People CHOOSE:

Death at home – comforted by loved ones (~90%)

Many people now GET:

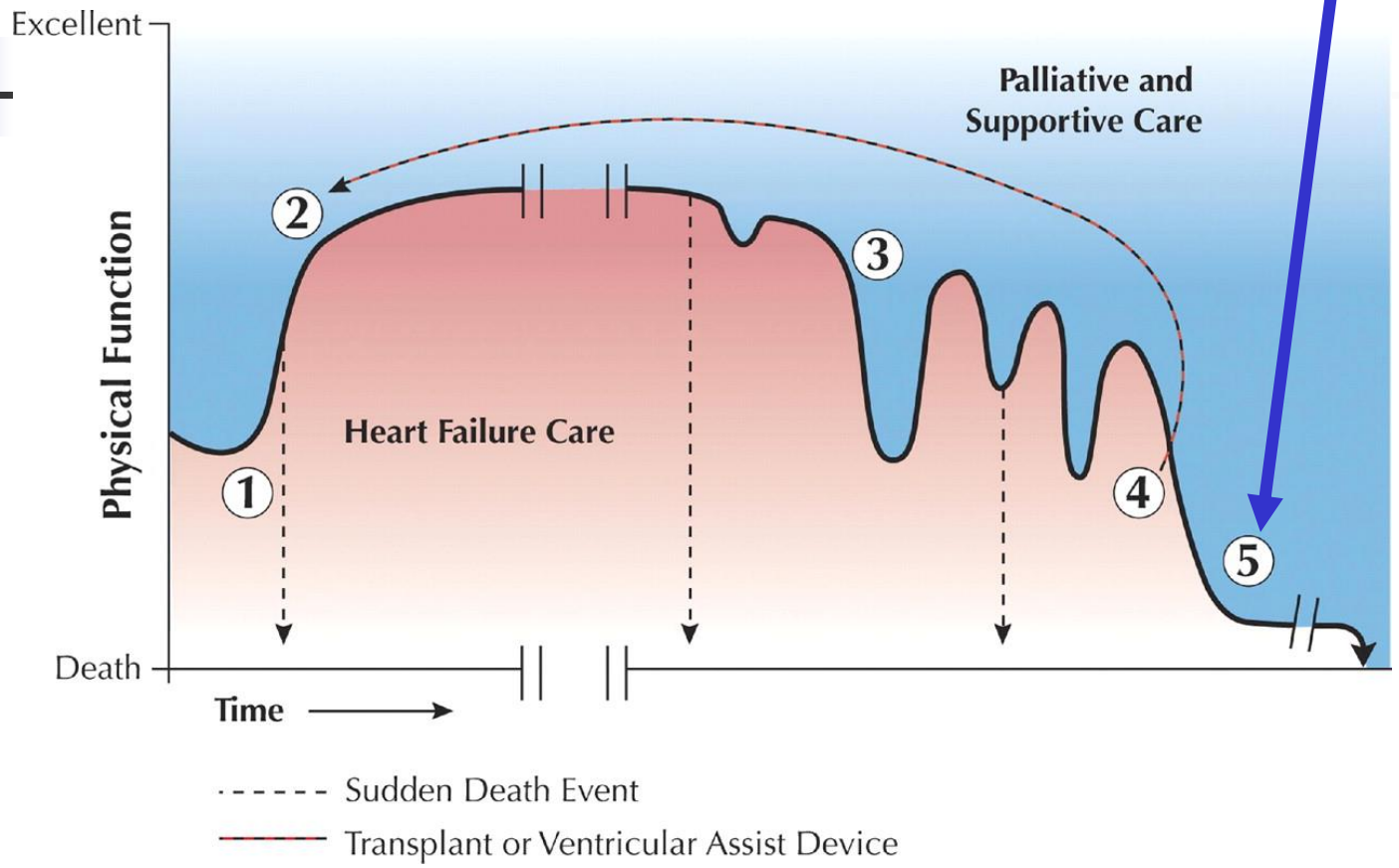
"Do Everything Possible" – intubated, sedated,restrained isolated … (~15-40%)



(often the result of choices made by default in moments of crisis!)

2005: New Research: **Common Trajectories** of:

FUNCTION* in final 5 years of Heart Patients / *"Final Chapter"



Goodlin, S. J. J Am Coll Cardiol 2009;54:386-396

JACC Journal of the American College of Cardiology

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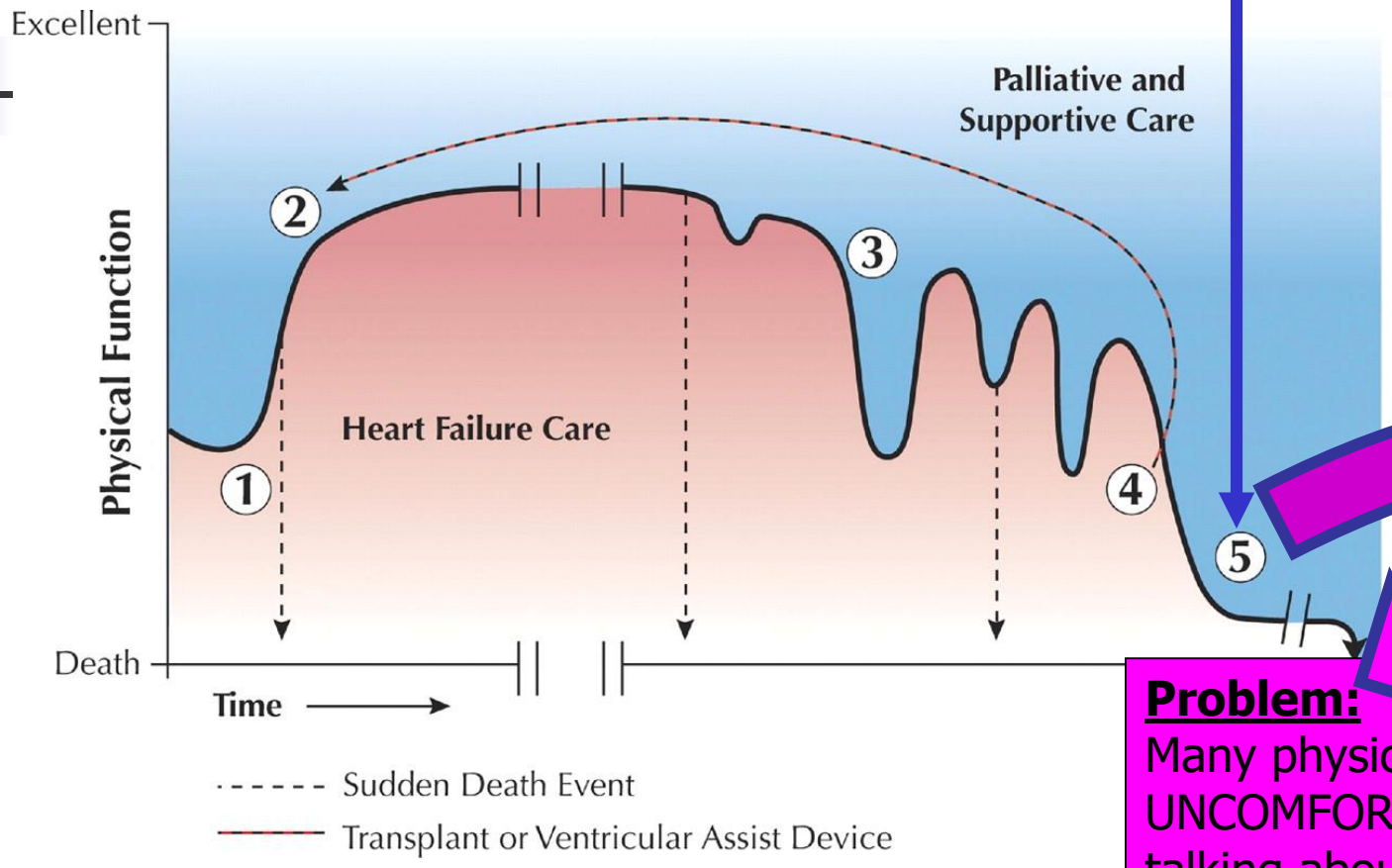

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Problem:
Many physicians are UNCOMFORTABLE talking about options for End-of-Life care until pt. in ICU for days ... or weeks (Final Chapter 5)!!!

So, How to address this Paradox?

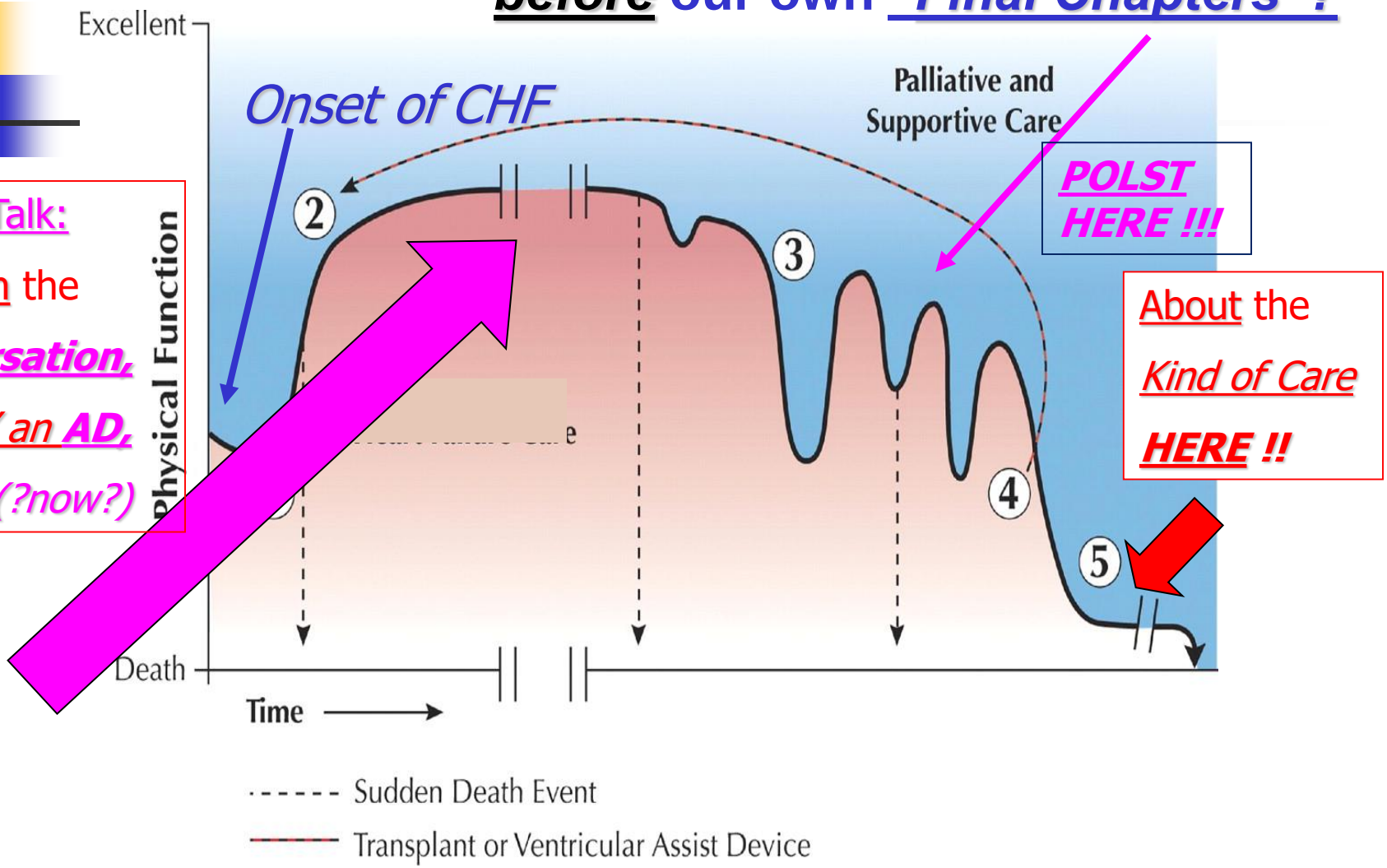
before our own "Final Chapters"?

Today's Talk:

1) Begin the ***Conversation,***

2) ***"Do" an AD,***

HERE *(?now?)*



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NEW **Question:** What kind of care in final chapter?

Most People CHOOSE:

Death at home – comforted by loved ones (~90%)

Many people still GET:

"Do Everything Possible" – intubated, sedated,restrained isolated … (~15-40%)

growth of Adv Care Planning & hospice since 1984

The *Challenge* : *and* The *Response* :

The "Silver Tsunami" (!)

from

Our Medical Community

Let the Conversation Begin !!

What to do ... Now?

Three Steps which will help ***YOU*** to choose/obtain care ***you prefer*** near end of ***YOUR*** life:

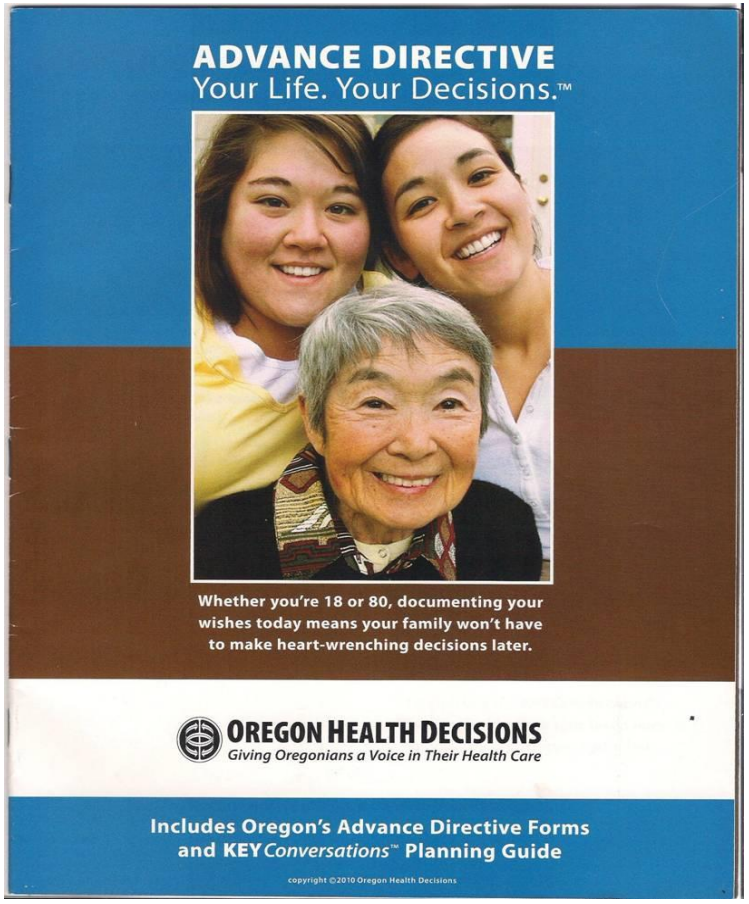
"Advance Care Planning" - 3 Parts:

- ***1)*** *series of* ***CONVERSATIONS***
  = the *MOST IMPORTANT*, by far!
  (*begin* ***NOW (?)*** ...with family, friends, caregivers...)
- **2)** completion of ***advance directive:*** ***(EARLY !)***
  a) detailed "living will" *preferences for EOL care;*
  b) appt. of *health care representative;*
- **3)** *and* ***POLST*** (*shorter, clearer, stronger*) ***(LATER!)***
  re: a) *resuscitation (?DNR vs. "full code");*
  b) intensity of final care *(?home, hospital, ICU?)*
  c) *? artificial nutrition/hydration* (tube feeding)

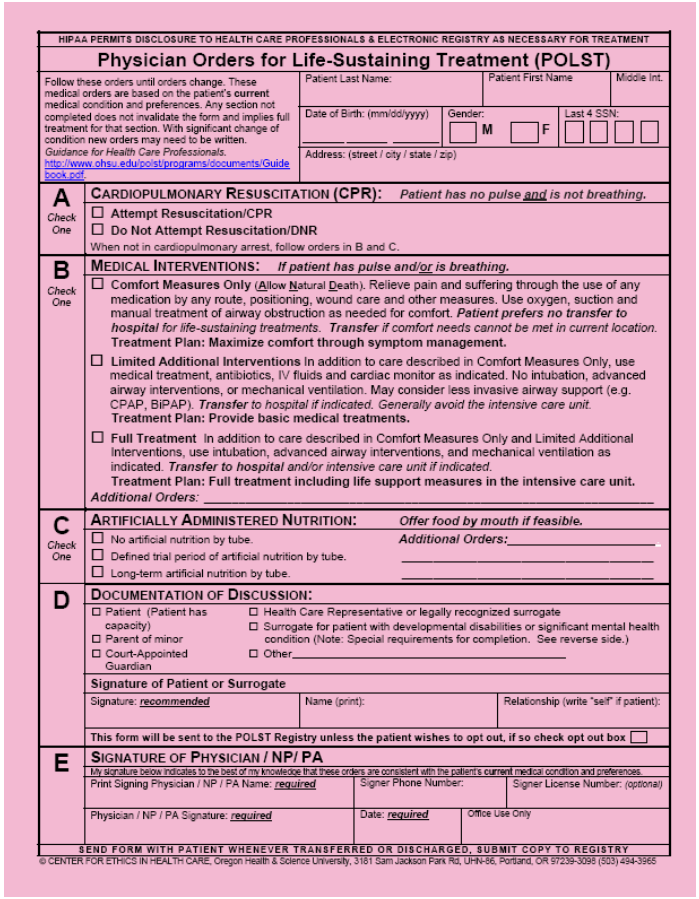
Document your choices (2 ways) !!!

(*Both* are helpful in final chapter)

Oregon Advance Directive – since 1993 (Now ?)



Oregon POLST Form – since 2001 (LATER !)



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

Physician Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.
Guidance for Health Care Professionals.
http://www.ohsu.edu/polst/programs/documents/Guidebook.pdf

Patient Last Name: | Patient First Name | Middle Int.

Date of Birth: (mm/dd/yyyy) | Gender: ☐ M ☐ F | Last 4 SSN: ☐☐☐☐

Address: (street / city / state / zip)

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *Patient has no pulse and is not breathing.*

☐ Attempt Resuscitation/CPR
☐ Do Not Attempt Resuscitation/DNR
When not in cardiopulmonary arrest, follow orders in B and C.

B Check One — **MEDICAL INTERVENTIONS:** *If patient has pulse and/or is breathing.*

☐ **Comfort Measures Only** (Allow Natural Death). 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: Maximize comfort through symptom management.

☐ **Limited Additional Interventions** 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 Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: Full treatment including life support measures in the intensive care unit.

Additional Orders: _____

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible.*

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D — **DOCUMENTATION OF DISCUSSION:**

☐ Patient (Patient has capacity)
☐ Parent of minor
☐ Court-Appointed Guardian
☐ Health Care Representative or legally recognized surrogate
☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)
☐ Other_____

Signature of Patient or Surrogate

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

This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box ☐

E — **SIGNATURE OF PHYSICIAN / NP/ PA**

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Print Signing Physician / NP / PA Name: ***required*** | Signer Phone Number: | Signer License Number: *(optional)*

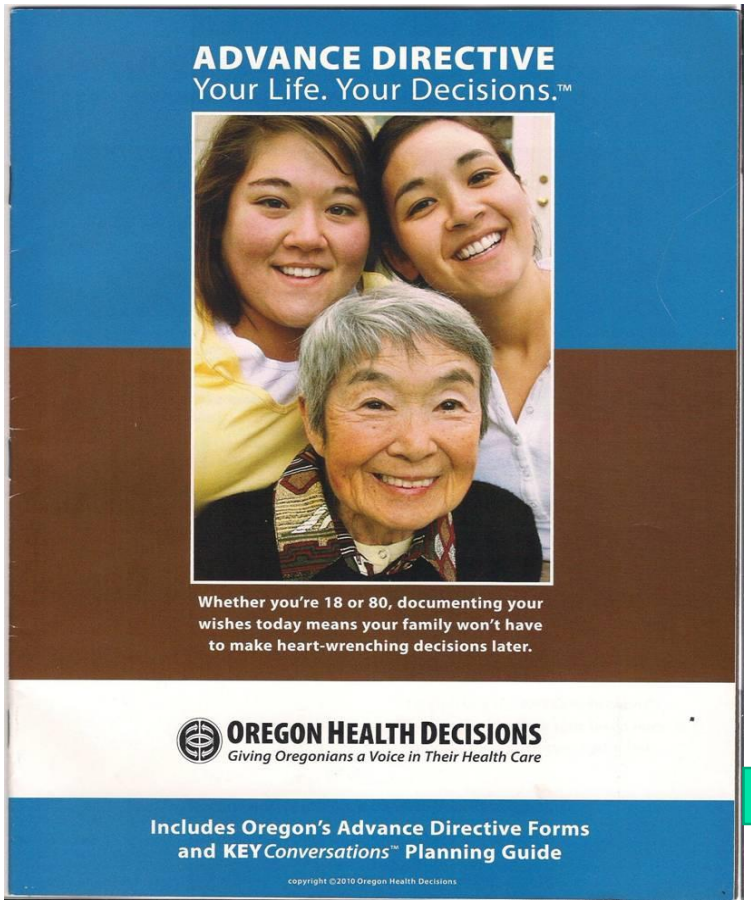
Physician / NP / PA Signature: ***required*** | Date: ***required*** | Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

First, the Advance Directive:

(mostly about ***PREFERENCES***)

Oregon Advance Directive – since 1993 (Now ?)



Contents:

- workbook to get started
- "living will" (24 choices!)
- appt. "Health Care Rep" (HCPOA)

Strengths:

- *very detailed!*
- good *guide to conversation*
- only *legal* way to appt HCRep

Weaknesses:

- Long! Complex! Redundant!
- ***NO*** mention ***CPR*** !
- Often ***Not Helpful*** in crisis !
- ***Not very effective*** (<50%)
- NOT **binding (preferences!)**

Oregon Advance Directive Form

Contents:

- General Info: (name, address, etc)
- ***A) "Health Care Instructions:"***
- - re each of 3 possible EOL situations: "Terminal" (< 6 mos)
- "Advanced Prog. Disease"
- "Permanently Unconscious"
- - for each, check *one of four choices:*
- *1. "Yes" to ALL possible Rx, including ICU, etc;*
- *2. Artificial nutrition and hydration, but NO other Rx;*
- *3. NO life-sustaining Rx (comfort care only);*
- 4. *Health Care Rep to decide* (consider preferences).

Oregon Advance Directive Form

Contents ... continued:

- B) "What Matters Most to Me" (optional):
- - Values, beliefs, etc.
- - Reaffirm: "I do NOT want life-sustaining procedures or RX ***", if..*** !!!
- - Other instructions re: CPR or not ... Or in particular situations ...
- (*preferences*) VSED (voluntary stop eating/drinking)
- Spoon feeding (if I cannot feed myself);
- COVID
- Place of death
- ?Hospice +/- Hospice House
- C) Sign: (mandatory) +/- Notarize (optional)
- *D) Witnesses (2)*
- *E) Appt of Health Care Rep* (only *LEGAL* part of the OR AD, optional)
- *Copy and distribute (strongly recommended)*

To access *current Oregon Advance Directive* ***Forms*** and ***User Guides*** :

- < oregon.gov/oha/PH/ABOUT/Pages/ADAC-Forms.aspx >

- Then, click "English"
- click "docx" for forms;
- or "User guide" for the User guide

- (*OR* ... Google: "Oregon Advance Directive")

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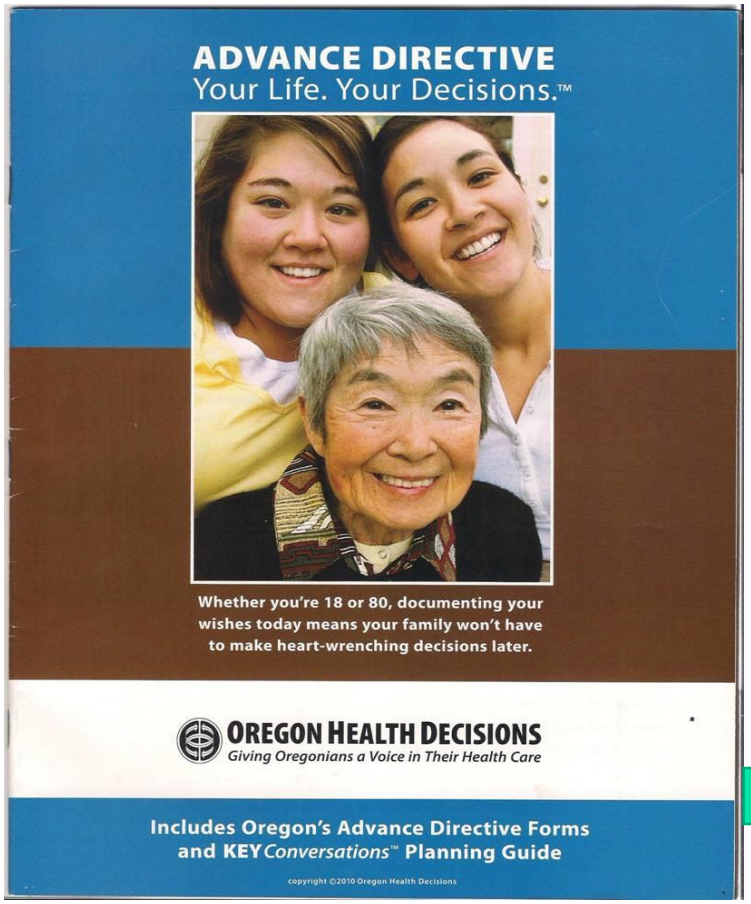

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If *Adv. Directives* *not* effective, what now?

POLST ?

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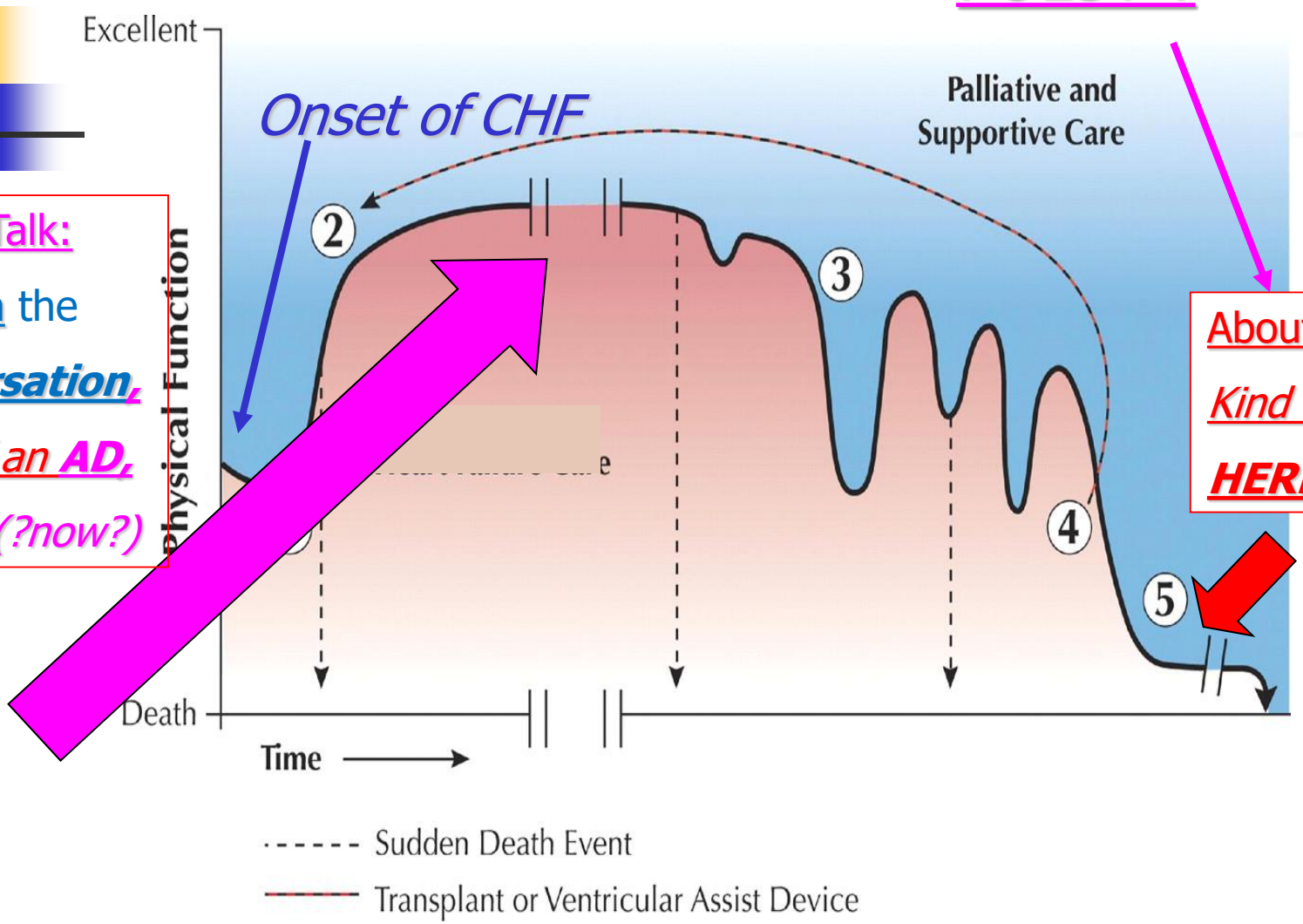


About the *Kind of Care* ***HERE !!***

Goodlin, S. J. J Am Coll Cardiol 2009;54:386-396

LATER: OREGON POLST FORM

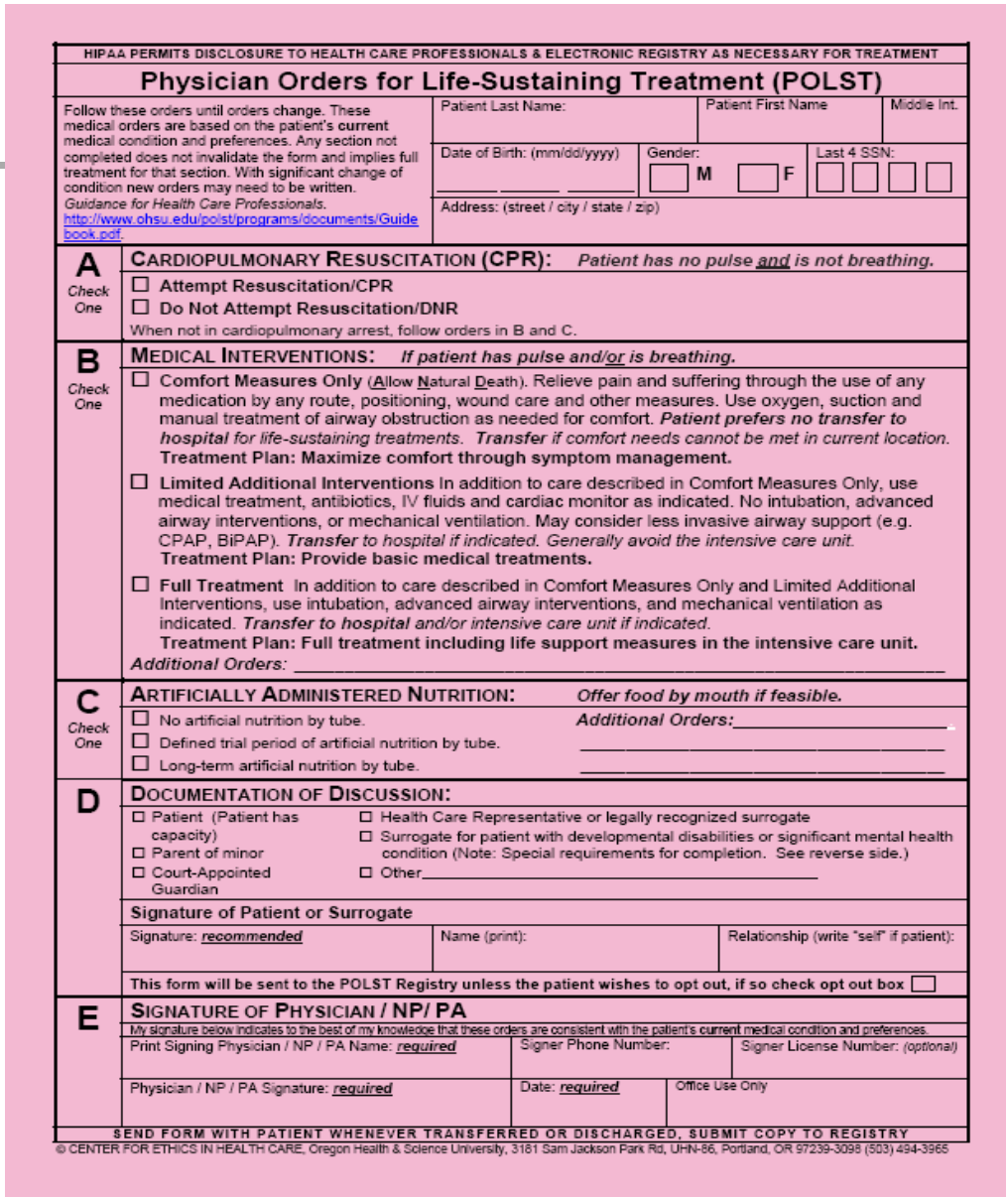
For: very elderly
frail
serious illness
(< 6 mos)

2 Decisions:

- shorter! (one page)
- clearer! (revised)
- stronger! (orders)
- *more* effective!

Since 2009: POLST Registry !

Revision of October, 2019
(not yet perfect … evolving!)



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Resources for Oregon POLST forms:

(Info, Guides, Forms, etc.)

- < https://www.oregonpolst.org >
- Or Google "Oregon POLST"

Differences between Advance Directive & POLST

	Advance Directive	POLST (Portable Orders for Life Sustaining Treatment)
Who is it for?	Everyone 18 and older.	People with a serious illness or who are very old and frail.
What kind of document is it?	It is a legal document.	It is a medical order.
Who signs it?	You fill it out and sign it. Also, your health care representative signs it and witnesses or a Notary.	Your doctor* fills it out with your input. Then signs it.
Do I need a lawyer?	No.	No.
Who keeps the form?	You keep the original where loved ones can find it. You give a copy to your health care representative and your doctor.	Your doctor's office keeps it and enters it into the electronic Oregon POLST Registry. They give you a copy that you post at home in a visible place like the fridge.
Can I change the form if I change my mind?	Yes. You can tear up the old one. Then write a new one where loved ones can find it. You give a copy to your health care representative and your doctor.	Yes. You can ask for an appointment with your doctor to change it.
What if there is a medical emergency and I cannot speak for myself?	Your health care representative speaks for you and honors your wishes.	The ambulance staff, hospital staff and doctors look for the medical orders in the electronic data base and follow them.

*Doctor means anyone who can sign a POLST form (MD, DO, NP, PA, ND).

Adapted with permission from The Next Door, Inc.

So, of these three,

which is the MOST important?

- ***1)*** *series of* ***CONVERSATIONS***

  (with family, friends, caregivers...)

- **2)** completion of ***advance directive:*** ***(EARLY !)***

  a) detailed "living will" ***preferences*** *for EOL care;*

  b) appt. of *health care representative;*

- **3)** *and* ***POLST*** (*shorter, clearer, stronger*) ***(LATER!)***

  a) *resuscitation (?DNR vs. "full code");*

  b) intensity of final care *(?home, hospital, ICU?)*

  c) *? artificial nutrition/hydration*

The Bottom Line: NOT so much about Documents …

It's "the *Conversation(s)*"* that *counts* most!!!

- … with our ***selves*** …
- … with our ***families*** *and* ***friends*** …
- … with our ***caregivers*** …
- … with our ***community !!!***

- *mostly about "What's Important"*: (? 4 things?)
- … *about "what kind of care" (?hospice?….)*
- … *with "those who matter most!!!"*

***TOOLS: AD, "Go Wish" cards, "TCP Starter Kit"**

How can I increase my chances … of receiving the care *I* wish for ?

- be an *Oregonian*!
- begin "*the conversations*" early *(now ?)*
- learn about your illnesses/Rx options;
  (? find doc who both *talks and walks* with you?)
- learn about *advance care planning* (?OLLI)
- create an ***Advance Directive***

- …*then,* **later** … (when *serious* illness) a ***POLST***

- Then … ***make every moment "count"*** **!!!**

"It's more about ***living well*** …than *dying* ***!!***"

What IF?

… we consider old age (or death) as:

an ***opportunity*** *for well-being? (!)*

- I.F.Stone (at 70, on *living well* into old age):

"As you move into it, even for someone like myself who gave up conventional religious views long ago, every day seems a gift from God. *When you feel that any day may be the day before your last, you savor it – the sky, the trees, the birds, the leaves underfoot."*

Stone, IF: NYTimes, Jan.22,1977

? Consider old age as:
an ***opportunity*** *for well-being? (!)*

- Epicurus (~300 BC):
- "It is *not* the *young* who should be considered fortunate, but the *old* … especially those who have *lived well,*
- because the ***young*** man in his prime wanders much by chance, vacillating in his beliefs,
- while the ***old*** man has docked in the harbor, having safeguarded his true happiness! "

from *Travels with Epicurus,*
Daniel Klein, 2012

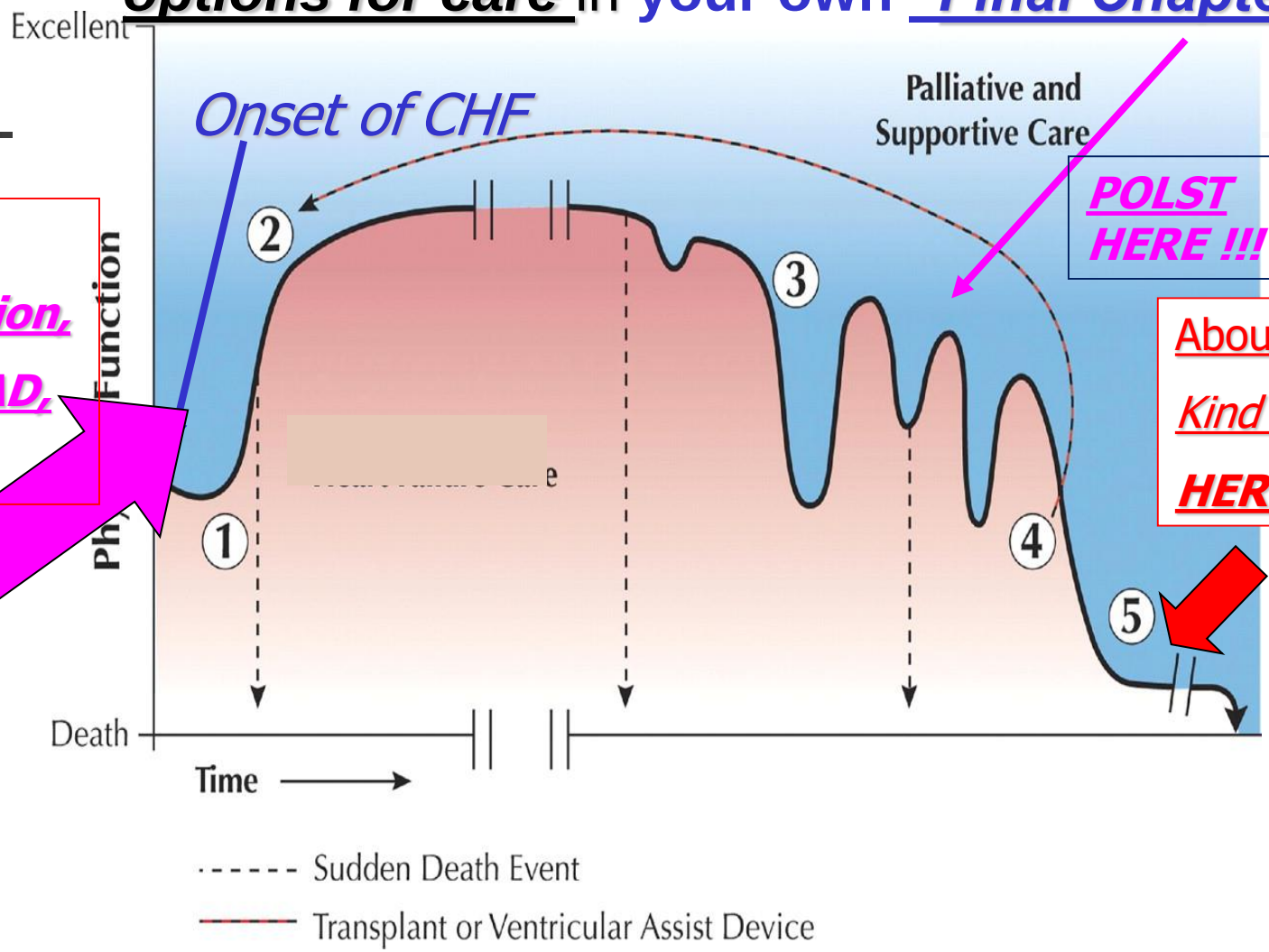
… more Epicurus …

- "Let no one be slow to seek wisdom when he is young, nor weary in the search of it when he has grown old. For no age is too early or too late for the well being of the soul. And to say that the season for studying wisdom has not yet come, or that it is past and gone, is like saying the season for happiness is not possible … "

So, now you have a little WISDOM about ...

options for care in your own ***"Final Chapters"?***

Begin the ***Conversation,*** & "Do" an ***AD,*** ***HERE !***



POLST HERE !!!

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One final Question: (perhaps the most important)

- How will *YOU* spend the precious time you have remaining?

- ? Will it be an *OPPORTUNITY* to ...

... ponder "things which matter most" ... *like* ...

the immensity of the sea? ...

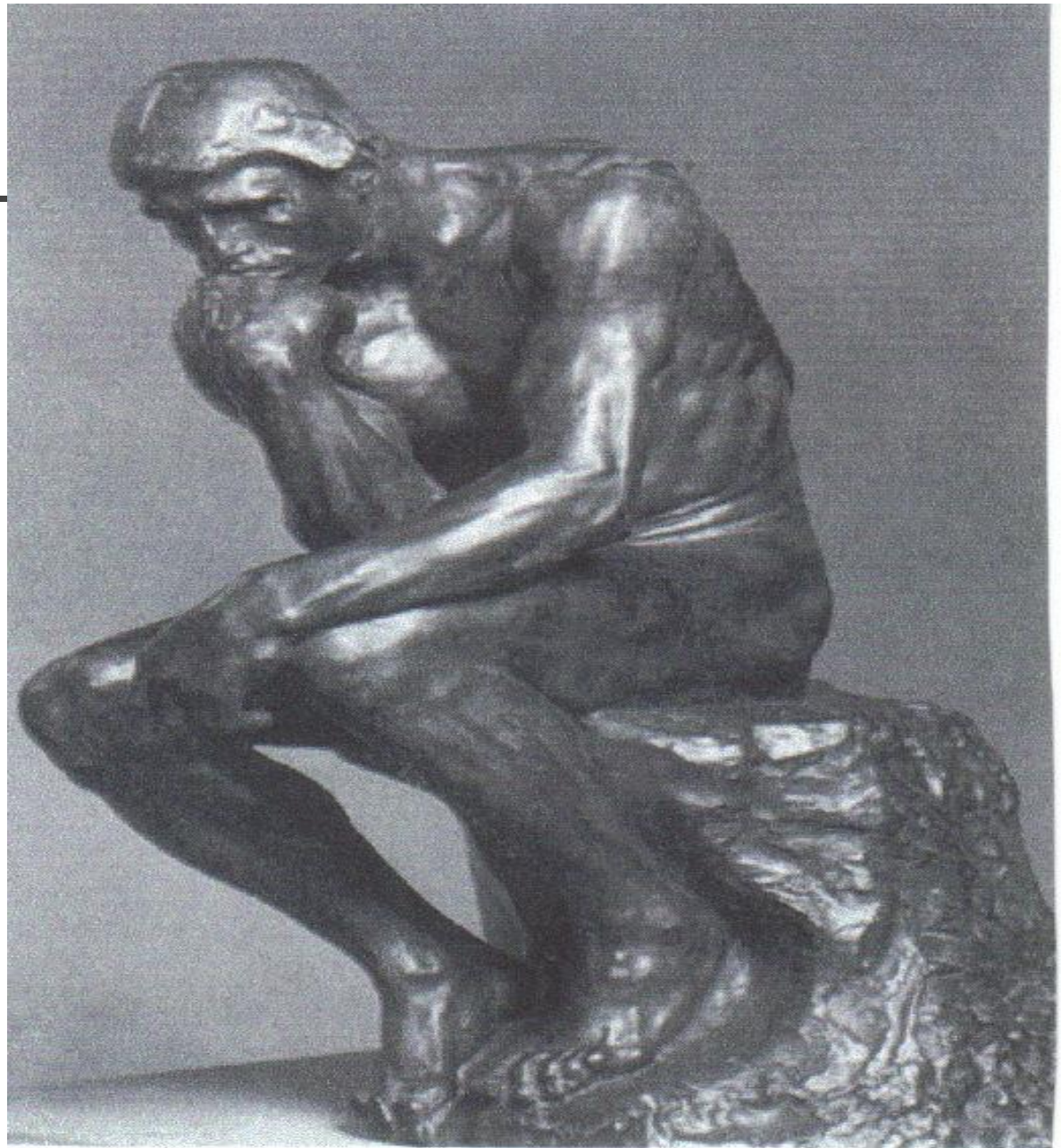
... *or* to enjoy a *trio* of *Glacier Lillies* dancing together ...

... Upper Applegate ... ? this Spring ?

NOW** is the time* ... to enjoy both what is ***near to us ...

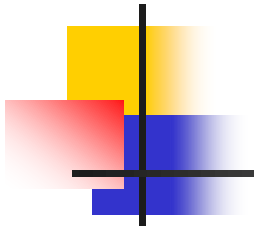
… and that which is incredibly immense and far away …

...an opportunity to ponder the spiritual aspect of our existence ... the great questions ... and the mysteries ...



And … a wonderful opportunity to-

… savor the great joy of ***family and friends*** *… in all our seasons!*



Thank you!

- NOW, Your
- Comments ?
- Questions ?
- ? Stories ?