

OREGON LOOKS TO TECHNOLOGY TO IMPROVE END-OF-LIFE CARE

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Matthew Gever

Oregon lawmakers are considering a slew of bills aimed at using health information technology (HIT) to improve the quality of care—both during and at the end of life.

One bill ([SB 451](#)) would create an electronic registry to house patients' "Physicians' Orders for Life-Sustaining Treatment" (POLST) forms, which would clarify patient's end-of-life treatment wishes.

"Health-care reform is about more than just expanding access," said Senator Laurie Monnes Anderson. "We also have to look at inefficiencies in our system to lower costs...and improve care."

The POLST document is a one-page, two-sided form, easily recognized by its bright pink color, that allows a patient to communicate his or her preferences for end-of-life treatment across different settings. A POLST differs from an advance directive in that it is intended for patients in the last stages of life or with a terminal illness, while in contrast, anyone may complete an advance directive at any time. Also, unlike advance directives, a physician must sign off on a POLST form, which turns the preferences stated on the form into medical orders. The POLST has several other requirements which can be found [here](#). Currently, at least 24 states have similar forms in use and [studies](#) have found that the process has helped to significantly reduce unwanted medical interventions and better educate patients about their end-of-life options.

If passed, SB 451 would create a central, computerized database of POLST forms for easy access across medical settings, which supporters hope will make accessing end-of-life wishes easier. "The POLST registry is about the wishes of patients and will give first responders the ability to respect those wishes," said Senator Alan Bates.

The writers of the bill expect the state to contract with Oregon Health & Science University, which already has a database in place that alerts emergency department physicians in one of their hospitals as to whether patients have a POLST form or an advance directive. Once established, the statewide database must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA); be subject to quality review and confirmation of data entry; have the capability to upload new POLST forms into the registry within twenty-four hours of receipt; and have efficient response time for the release of registry information to authorized emergency medical personnel.

The state would provide \$451,000 in general funds to create the registry, and the federal government would kick in another \$286,000.

"Without the coordination provided by a POLST registry, emergency resources will be spent on costly interventions for patients against their wishes," said a fact sheet from the state's Office of Health Policy and Research (OHPR).

Other Issues

Lawmakers are looking to HIT to help solve other health-care-related problems in the state. Like many states, Oregon is facing a dearth of health-care professionals, and it lacks the means to track their supply and distribution. [SB 457](#) would change that by requiring the regulatory boards of health professionals to collect data on their licensees for a centralized database run by OHPR. "A health-care workforce database will allow us to identify shortages in services," said Senator Bates.

To encourage more providers to adopt electronic records, the legislature is considering [SB 452](#). The bill would create an oversight council charged with developing long-term plans to implement HIT statewide and to form a purchasing collaborative to get bulk discounts on HIT products. The council would comprise various stakeholders such as providers, insurers, patients and privacy experts.

To accomplish these and other ends, legislators are hoping to get a share of the \$19 billion for HIT contained in the federal stimulus package. "These bills set the stage for Oregon to take advantage of federal dollars to modernize our health-care system," said Senator Richard Devlin.



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Find POLST Paradigm information and forms for:

Program Requirements

A POLST Paradigm program must meet specific program requirements. These requirements are defined by members of the National POLST Paradigm Initiative Task Force who have experience and expertise in POLST Paradigm development.

Program Requirements

In order to be considered an endorsed POLST Paradigm Program, the Program must include these requirements:

- The form constitutes a set of medical orders
- The process includes ongoing training of health care professionals across the continuum of care about the goals of the program as well as the creation and use of the form
- Use of the form is recommended for persons who have advanced chronic progressive illness, those who might die in the next year or anyone wishing to further define their preferences of care
- The National POLST Paradigm Initiative Task Force strongly recommends that all POLST Paradigm programs require the signature of either the patient or the patient's legal representative to make the form valid, as allowed by statute and regulations. The signature of the patient (or the patient's legal representative if the patient lacks decision-making capacity) provides evidence that patients or their legal representatives agree with the orders on the form. In this respect, the requirement that patients or their legal representatives review and sign the form provides a safeguard for patients that the orders on the form accurately convey their preferences. Completion of the POLST form is voluntary, and the goal of such a form is to ensure that the patient receives the level of care desired.
- The form requires a valid Physician (Nurse Practitioner or Physician Assistant accepted depending upon program) signature and date of signature
- The form may be used either to clarify a request for all medically indicated treatments including resuscitation or to limit medical interventions.
- The form provides explicit direction about resuscitation status if the patient is pulseless and apneic
- The form also includes directions about other types of intervention that the patient may or may not want. For example, decisions about transport, ICU care, antibiotics, artificial nutrition, etc.
- The form accompanies the patient, and is transferable and applicable across care settings (i.e. home, long term care, hospice, EMS, hospital)
- The form is uniquely identifiable, standardized, with a uniform color within a state/region
- There is a plan for ongoing evaluation of the program and its implementation

Optional Elements

The following issues may be handled by programs in different ways depending on state law and local preferences.

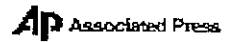
- Ideally, a legal surrogate should be able to make decisions about treatment choices for a patient without decision-making capacity, but states have varying laws regarding surrogates and decision making.
- Some states may recognize the form as the only out-of-hospital DNR form; in others there may be other means of DNR ID as well. Use of the form is always voluntary.
- Ideally, states would accept forms completed in other states (reciprocity).

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Wash. state has first death under new suicide law

 AP Associated Press

By RACHEL LA CORTE, Associated Press Writer

1 hr 16 mins ago

OLYMPIA, Wash. – A 66-year-old woman with terminal cancer has become the first person to die under Washington state's new assisted suicide law, an advocacy group said Friday.

Linda Fleming, of Sequim, died Thursday night after taking drugs prescribed under the "Death with Dignity" law that took effect in March, said Compassion & Choices of Washington.

The organization said Fleming was diagnosed last month with advanced pancreatic cancer. She would have had to have been diagnosed by two doctors as terminal in order to qualify for assisted suicide.

The group said Fleming died at home with her family, her dog and her physician at her bedside.

"The pain became unbearable, and it was only going to get worse," Fleming said in a statement released by the organization.

A physician prescribed the medication, but under the law, patients must administer the drugs themselves.

Chris Carlson, who campaigned against the law with the Coalition Against Assisted Suicide, said the death was "a sad occasion and it diminishes us all."

The new law was approved in November with nearly 60 percent of the vote, making Washington the second state in the nation with voter-approved assisted suicide legislation. It is based on a 1997 Oregon measure, under which about 400 people have ended their lives.

Under both states' laws, physicians and pharmacists are not required to write or fill lethal prescriptions if they are opposed to the law. Some hospitals have opted out of the law, which precludes their doctors from participating on hospital property.

In December, a Montana district judge ruled that doctor-assisted suicides are legal. That decision, based on an individual lawsuit rather than a state law or voter initiative, is before the Montana Supreme Court, but doctors there are allowed to write prescriptions for life-ending drugs pending the appeal. It is not known if any have done so because no reporting process was in place.

In Washington, any patient requesting fatal medication must be at least 18, declared competent and be a state resident.

Two doctors would have to certify that the patient has a terminal condition and six months or less to live. The

patient must also make two oral requests, 15 days apart, and make a written request witnessed by two people.

As of Friday, the state Department of Health has received six forms from pharmacists saying they have dispensed the life-ending drugs.

The state also has received five forms from individuals requesting medication to "end my life in a humane and dignified manner," and five doctors have completed forms complying with the rules of the new law.

The Health Department will report annually on the ages, genders and illnesses of the people who file forms with the state, but the individual forms people complete are exempt from state open records laws.

On the Net:

Center for Health Statistics, Death with Dignity Act, <http://www.doh.wa.gov/dwda/formsreceived.htm>

Compassion & Choices of Washington, <http://www.candcofwa.org>

COMPASSION & CHOICES OF WASHINGTON

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How can I get a POLST form?

POLST forms can be obtained from your healthcare provider or by contacting C&C at 206-256-1636 or email info@CandCoWA.org

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Text Size **A** **A**

Physician Orders for Life-Sustaining Treatment (POLST)

A Physician Orders for Life-Sustaining Treatment (POLST) form (formerly called the EMS - No CPR form) is intended for any adult, 18 years of age or older, with serious health conditions.

The POLST form accomplishes two major purposes:

- It is portable from one care setting to another.
- It translates wishes of an individual into actual physician orders.

POLST In The News

EMTs are listening to patients' dying wishes

By Carol M. Ostrom

The Seattle Times, 5/9/06

Creative, combined care plan provides best of both worlds

By Liz Taylor

The Seattle Times, 6/20/05

Why should I make a POLST?

The truth is that healthcare providers frequently ignore advance directives, and the law isn't much help. No state forces a doctor or hospital to follow instructions in an advance directive. POLST, however, represents your wishes as clear medical orders. POLST improves your chances of getting what you want and avoiding what you do not want at the end of life. We recommend POLST to all our clients.

You (or your health care agent) and your physician may use POLST to write clear and specific medical orders that indicate what types of life-sustaining treatment you want or do not want at the end of life. Both the patient and a physician must sign the bright green form in order for it to be honored by other health care professionals.

No witnessing or notarizing is required.

Emergency Medical Services (EMS) personnel are required to honor POLST, and it remains with you if you are transported between care settings.

The POLST form is relatively new in Washington, and many physicians are still unaware of it.

If your physician does not have POLST forms available, ask her or him to contact the Washington State Medical Association, or contact our office to request one.

Properly completed, the POLST form is probably the most effective advance directive because your wishes are expressed as medical orders.

PO BOX 61369 SEATTLE WA 98141

PH: 206.256.1636

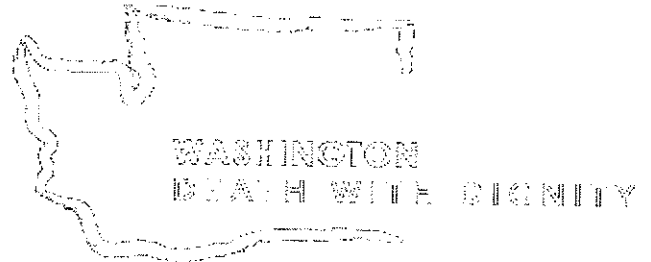
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Washington Death with Dignity Act- Initiative 1000

- [Click here to read the initiative in PDF format](#)
- The FAQ and Death with Dignity FORMS are available at [Department of Health Website](#).
- Patients should consider talking to their doctor now about their end of life wishes and we strongly advise that you have this conversation face to face with your doctor. This [Letter to My Physician](#) can be used to help you gather your thoughts to have this conversation.

Washington State took a tremendous step on November 4 by passing Initiative 1000. We are grateful to the thousands of volunteers and supporters who made this victory possible.

Initiative 1000 is modeled after Oregon's Death with Dignity law and C&C's own guidelines and safeguards. Just as with Oregon's law, our new law will be implemented and enforced by the state of Washington, through the Department of Health. C&C led the Initiative 1000 campaign from the beginning, and we will be monitoring the implementation process closely to make sure that the new law is implemented correctly and completely.

The state has 120 days to implement Initiative 1000, which means that the law will not take effect until March 5, 2009. We will keep this page updated as more information becomes available. Scroll down to read more about the provisions of this law.

If you are a terminally ill individual who is seeking to avoid suffering at the end of life, we can help. Compassion & Choices of Washington has offered direct client services to terminally ill individuals for the past fifteen years, and we will continue to provide those services to clients who qualify under our [guidelines and safeguards](#). To request case management, call our office at 206-256-1636 or 1-877-222-2816, toll-free. (More details about the services we provide are available on [this page](#).)

If you are a physician seeking consultation about I-1000, we have physicians on our board

and advisory committee who are available for consultation.

The best way to stay informed is to sign up for our online newsletter. Enter your email address below to join our email list.

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Ten Years of Dignity in Oregon

I-1000 mirrors the Oregon Death with Dignity Act, which has been in place for over 10 years. The Oregon law was upheld by the U.S. Supreme Court and approved twice by voters.

The most significant impact of the Death with Dignity Act in Oregon has been to improve the care for all dying patients, by increasing awareness among doctors, allowing an open and honest conversation between doctors and patients, improving pain management and palliative care, and providing patients with a sense of control and peace of mind.

Earlier this year, The Oregonian newspaper wrote that the law "helped elevate end-of-life care" and that "in a decade of experience with the law, no abuses have shown up." The Seattle Times added that "those it affects, and their families, will be thankful for its passage."

Independent studies of Oregon's Death with Dignity law prove that the safeguards protect patients, prevent misuse and coercion, and allow mentally competent, terminally ill patients the option of a peaceful, dignified death. People with terminal cancer and AIDS would have the right to decide whether to end their intolerable suffering.

The Safeguards Work

There are multiple safeguards in Washington's death with dignity law. These safeguards include independently witnessed oral and written requests, two waiting periods, mental competency and prognosis confirmed by two physicians, and self-administration of the medication. Only the patient – and no one else – may administer the medication.

Washington's Death with Dignity safeguards:

1. The patient must be at least 18 years old
2. The patient must be a resident of the state of Washington
3. The patient must be terminally ill - not disabled, but diagnosed as terminally ill
4. The terminally ill patient must have 6 months or less to live, as verified by two physicians
5. Three requests for Death with Dignity must be made (two verbal and one written)
6. Two physicians must verify the mental competence of the terminally ill patient
7. The request must be made voluntarily, without coercion, as verified by two physicians

8. The terminally ill patient must be informed of all other options, including palliative care, pain management and hospice care
9. There is a 15 day waiting period between the first oral request and the written request
10. There is a 48 hour waiting period between the written request and the writing of the prescription
11. The terminally ill patient's written request must be independently witnessed, by two people, at least one of whom is not related to the patient or employed by the health care facility
12. The terminally ill patient is encouraged to discuss their decision with family (not required because of confidentiality laws)
13. Only the terminally ill patient may self-administer the medication
14. The patient may change their mind at any time

The safeguards in Washington's Death with Dignity Act ensure that terminally ill patients are making a voluntary and informed decision. These same safeguards have worked in Oregon for over 10 years. Patients must be terminally ill, must have less than 6 months to live, the patient must make two independently witnessed requests, and every step of the process must be approved by two doctors.