Testimony for the Washington State House of Representatives

My name is Hilary Walker, and I am a geriatric occupational therapist currently leading the System-wide medical advance care planning program for PeaceHealth's medical system. I am also part of the WA POLST task force.
I want to share two stories that speak to the essential need for clear POLST programs and support.

Last week, I met with the family of an 80 year o;d woman who had been hospitalized for a stroke. When patient initially had her stroke, she was home, and when her son called 911, the patient refused to go to the hospital. The family was able to encourage her to go, and yet they did not expect how long they would keep her, during which time she was confused and asked to go home. After 5 days, when she finally returned home, despite having mental changes and difficulty talking, this woman was very adamant that “next time, I don’t want to go to the hospital. I want to be allowed to die in my own home and not in the hospital. I have lived a full life”. The son shared this with her primary care provider, who referred them to our ACP program for support. Son asks “How do I ensure my mother's wishes are honored by 911 and any caregivers we have in the home”? The answer - is a POLST form, which could be signed by the son (only child and next of kin). An advance directive would not have been a good option in this case. In addition to the fact that she was no longer competent to sign an advance directive, we also have the problem of EMS being unable to honor a legal document; they need orders. Her PCP was able to complete the POLST orders with her son as her surrogate, also signing them.

The POLST helps support known patient wishes, and can be signed by a surrogate decision-maker after the patient has lost capacity.

The following person I want to tell you about is a 75-year-old who we will call George. George has advanced lung and heart disease and is being followed by the Outpatient Palliative Care team. After lots of meaningful conversations with the patient and his spouse and children about his condition and what he would want in an emergency, he and his doctor completed a POLST for DNR/selective treatment to allow a natural death in the event of a cardiac arrest. It also said he would be willing to have a hospital transfer for all other events but wants to avoid being in ICU —he did not want tubes or a breathing machine. One day, while he was at the local senior center, George had a cardiac arrest. 911 was called, his POLST form was sent home, and there was no way for the EMTs to know that he had a DNR order. George receives CPR and is intubated on the way to the hospital. The family is called and is very upset that the patient is now on life support. They are told he will not survive the removal of life support, and family must now decide to discontinue treatment

If George had been wearing a certified pendant or bracelet indicating the DNR order, or if the EMTs had been able to access his POLST via the registry, they could have administered comfort to him during his final moments, giving his family peace of mind knowing that his wishes were honored.

A POLST helps protect some of our most vulnerable patients by translating previously expressed preferences into medical orders. A registry and jewelry can help support patients who have established medical orders in a POLST, but who are still active in their communities.