KŌKUA MAU
"Continuous Care"

A Movement to
Improve Care

Updates to POLST - 2023

Jeannette G. Koijane, MPH

Executive Director, Kōkua Mau

Who is *Kōkua Mau*?

- 501(c)3, community benefit org., statewide (not a state agency) since 1999
- Membership – health plans, hospitals, hospices, long term care, spiritual care, home health, Aging Network
- Passionate volunteers across the state
- Concentrate on the continuum of care: ACP, including POLST, palliative care, hospice care and bereavement

Kōkua Mau
"Continuous Care"
A Movement to Improve Care

Three areas of activity

1. Work with people who may be facing serious illness & their loved ones to understand the decisions they may need to make – as early as possible!
2. Provide professional networking & training
3. Change the System - Policy & Legislation

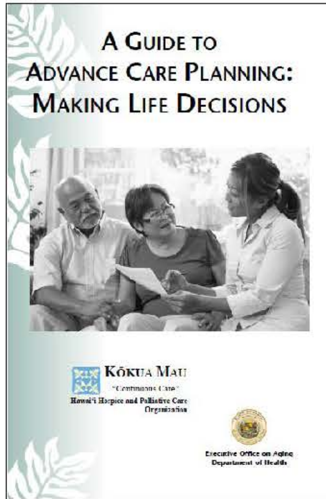
KŌKUA MAU
"Continuous Care"
A Movement to Improve Care

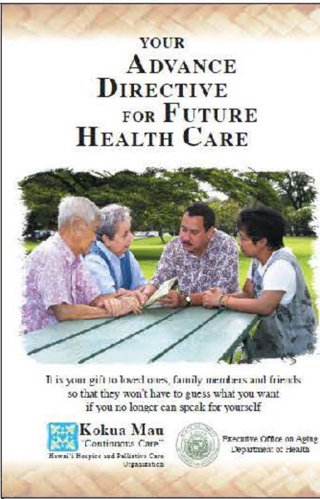
A Movement for Change

Kōkua Mau is leading a *movement* that aims to make advance care planning and open communication about care and support for those with serious illness and their loved ones, including end-of-life care, *the cultural norm*

Kōkua Mau
"Continuous Care"
A Movement to Improve Care

Kōkua Mau Resources





HAWAI'I ADVANCE HEALTH CARE DIRECTIVE

Questions about CPR

Kokua Mau - Hawai'i Hospice and Palliative Care Organization

A GUIDE FOR DECISION MAKING

Tube Feeding

Kokua Mau - Hawai'i Hospice and Palliative Care Organization

A GUIDE FOR DECISION MAKING

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

A Provider's Guide to POLST
(Provider Orders for Life-Sustaining Treatment)
Maintained for Hawai'i by Kōkua Mau

What is POLST?

What is POLST?
Provider Orders for Life-Sustaining Treatment
A Consumer Guide to POLST
Maintained for Hawai'i by Kōkua Mau

FREQUENTLY ASKED QUESTIONS (FAQ)

Chinese simplified Hawaii Advance Health Care Directive
Chinese traditional Hawaii Advance Health Care Directive
Ilocano Hawaii Advance Health Care Directive
Japanese Hawaii Advance Health Care Directive
Korean Hawaii Advance Health Care Directive
Marshallese Hawaii Advance Health Care Directive
Spanish Hawaii Advance Health Care Directive
Tagalog Hawaii Advance Health Care Directive
Tongan Hawaii Advance Health Care Directive
Vietnamese Hawaii Advance Health Care Directive

Since June 2016 the Hawaii POLST Form is available in 10 languages.

- Chinese simplified POLST Form for Hawai'i
- Chinese traditional POLST Form for Hawai'i
- Ilocano POLST Form for Hawai'i
- Japanese POLST Form for Hawaii
- Korean POLST Form for Hawaii
- Marshallese POLST Form for Hawaii
- Spanish POLST Form for Hawai'i
- Tagalog POLST Form for Hawai'i
- Tongan POLST Form for Hawaii
- Vietnamese POLST Form for Hawai'i

Kōkua Mau
"Continuous Care"
A Movement to Improve Care

http://www.kokuamau.org/

Documents to support wishes for care: Advance Directives

- Advance Health Care Directives:
  - Names the Health Care Power of Attorney aka Health Care Agent
  - Gives direction to agent and health care team for decision-making
  - Should be reviewed and confirmed still accurate upon intake

Kōkua Mau
Continuous Care
A Movement to Improve Care

Advance Health Care Directive

HAWAI'I ADVANCE HEALTH CARE DIRECTIVE

My name is: ____
Last First Middle initial Date of Birth Date

PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:
I designate the following individual as my agent to make health care decisions for me:

Name and relationship of individual designated as health care agent
Street Address City State Zip
Home Phone Cell Phone E-mail

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

Name and relationship of individual designated as health care agent
Street Address City State Zip
Home Phone Cell Phone E-mail

AGENT'S AUTHORITY AND OBLIGATION:
My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:
My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

__ ☐ If I mark this box, my agent's authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care. I can revoke this authority at any time as long as I have mental capacity.

PART 2: INDIVIDUAL INSTRUCTIONS (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

A. END OF LIFE DECISIONS
- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.

THEN I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: Check only one of the following boxes. You may also initial your selection.

__ ☐ I want to stop or withhold medical treatment that would prolong my life.

OR

__ ☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent Page 1 of 3

Available to download on Kōkua Mau Website: www.Kokuamau.org

KŌKUA MAU
Continuous Care
A Movement to Improve Care

AHCD – Part 1:
Health Care Power of Attorney (HCPOA)

HAWAIʻI ADVANCE HEALTH CARE DIRECTIVE

My name is: ____
Last   First   Middle initial   Date of Birth   Date

PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:
I designate the following individual as my agent to make health care decisions for me:

____
Name   and relationship of individual designated as health care agent
____
Street Address   City   State   Zip
____
Home Phone   Cell Phone   E-mail

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

____
Name   and relationship of individual designated as health care agent
____
Street Address   City   State   Zip
____
Home Phone   Cell Phone   E-mail

- Who do you trust to make health care decisions for you when you cannot?
  - Familiar with your personal values
  - Willing and able to make decisions
- Doesn't need to be a family member.
- Select alternate

AHCD - Part 2 Section A: End of Life Decisions

PART 2: INDIVIDUAL INSTRUCTIONS (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

A. END OF LIFE DECISIONS

- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.

THEN I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: Check only one of the following boxes. You may also initial your selection.

___ ☐ I want to stop or withhold medical treatment that would prolong my life.

OR

___ ☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent Page 1 of 3

Becomes effective only when:

- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits

Choice - Prolong or Not to Prolong Life

- " I want to stop or hold medical treatment that would prolong my life"

  OR

- "I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards"

KŌKUA MAU
Continuous Care
A Movement to Improve Care

AHCD – Part 2
Section B: Artificial Nutrition & Hydration

PART 2: INDIVIDUAL INSTRUCTIONS (CONTINUED) (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:
Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

__ ☐ If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

C. RELIEF FROM PAIN:

__ ☐ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. OTHER

__ ☐ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

KŌKUA MAU
Continuous Care
A Movement to Improve Care

AHCD Part 2 –
Section E: What is Important to Me?

Kōkua Mau
Continuous Care
A Movement to Improve Care

- What makes life meaningful?
- What would make quality of life unacceptable?
- If a trial of support is wanted – how long would they want?

E. WHAT IS IMPORTANT TO ME: (Optional. Add additional sheets if needed.) The things that I value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple):

____

____

My thoughts about when I would not want my life prolonged by medical treatment (Examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

Must be signed in the presence of:

A Notary Public

OR

Two Witnesses

Witnesses

- Must be 18 years or older
- Cannot be your health care agent, a health care provider or an employee of a health care facility
- One witness cannot be a relative or have inheritance rights

What is POLST?

Provider
Orders for
Life
Sustaining
Treatment

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

FIRST follow these orders. THEN contact the patient's provider. This Provider Order form is based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name

First/Middle Name

Date of Birth | Date Form Prepared

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): ***** Person has no pulse and is not breathing *****

☐ **Attempt Resuscitation/CPR (Section B: Full Treatment required)** ☐ **Do Not Attempt Resuscitation/DNAR** (Allow Natural Death)

If the patient has a pulse, then follow orders in **B** and **C**.

B Check One

MEDICAL INTERVENTIONS: ***** Person has pulse and/or is breathing *****

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). ***Transfer*** to hospital if indicated. Avoid intensive care.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders:

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Always offer food and liquid by mouth if feasible and desired.***
(See Directions on next page for information on nutrition & hydration)

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

Additional Orders:

D Check One

SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:

☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate
☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Provider Name	Provider Phone Number	Date
Provider Signature (required)	Provider License #	

Signature of Patient or Legally Authorized Representative
My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

Signature (required)	Name (print)	Relationship (write 'self' if patient)

Summary of Medical Condition	Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

KŌKUA MAU
Continuous Care
A Movement to Improve Care

POLST in Hawaii

Effective 2009, Updated 2014 and 2023

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAI'I

FIRST follow these orders. THEN contact the patient's provider. This Provider Order form is based on the person's **current medical condition and wishes**. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.
POLST is a medical order. It is not an **Advance Directive** and is not intended to replace that document.

Patient's Last Name
First/Middle Name
Date of Birth | Date Form Prepared

A Choose One — **CARDIOPULMONARY RESUSCITATION (CPR):** ***** Person has no pulse and is not breathing *****

☐ **Yes CPR - Attempt resuscitation** (Section B: Full Treatment **required**)
☐ **No CPR. Do Not Attempt Resuscitation** (**Allow Natural Death**)
If patient has a pulse, follow orders in Sections **B** and **C**

B Choose One — **MEDICAL INTERVENTIONS:** ***** Person has pulse and/or is breathing *****

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes intensive care as needed.
☐ **Selective Treatment – goal of treating medical conditions and restoring function while avoiding intensive care and resuscitation.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive respiratory support.
☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.** Relieve pain and suffering with medication by any route as needed, use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.
Additional Orders: ____

C Choose One — **ARTIFICIALLY ADMINISTERED NUTRITION:** ***Always offer food and liquid by mouth if feasible and desired.***
(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube ☐ Defined trial period of artificial nutrition by tube Goal: ____
☐ Long-term artificial nutrition by tube
Additional Orders: ____

D Choose One — **SIGNATURES AND SUMMARY OF MEDICAL CONDITION** - Discussed with:

☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:
☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate
☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Patient or Legally Authorized Representative My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.
Signature (required) | Name (print) | Relationship (write 'self' if patient)

Signature of Provider (Physician/APRN/PA licensed in the state of Hawai'I.) My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.
Print Provider Name | Provider Phone Number | Date
Provider Signature (required) | Provider License #
Summary of Medical Condition | Official Use Only

SEND THIS 2-PAGE FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED POLST pg 1 of 2

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle) | Date of Birth | Gender

Patient's Preferred Emergency Contact (Listing a person here does not make them a Legally Authorized Representative. Only an Advance Directive or state law grants that authority.)
Name | Relationship to Patient | Phone Number
Health Care Professional Preparing Form | Preparer Title | Phone Number | Date Form Prepared

E — **SURROGATE SELECTED BY CONSENSUS OF INTERESTED PERSONS (Legally Authorized Representative as outlined in section D)**

I make this declaration under the penalty of false swearing to establish my authority to act as the legally authorized representative for the patient named on this form. The patient has been determined by the primary physician to lack decisional capacity and no health care agent or court appointed guardian or patient-designated surrogate has been appointed or the agent or guardian or designated surrogate is not reasonably available. The primary physician or the physician's designee has made reasonable efforts to locate as many interested persons as practicable and has informed such persons of the patient's lack of capacity and that a surrogate decision-maker should be selected for the patient. As a result I have been selected to act as the patient's surrogate decision-maker in accordance with Hawai'i Revised Statutes §327E-5. I have read section C below and understand the limitations regarding decisions to withhold or to withdraw artificial hydration and nutrition.
Signature (required) | Name | Relationship

DIRECTIONS FOR HEALTH CARE PROFESSIONAL

Completing POLST
- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a Physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) licensed in the state of Hawai'i and the patient or the patient's legally authorized representative to be valid. Verbal orders by providers are not acceptable.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
- The most recently completed valid POLST form supersedes all previously completed POLST forms. This form does not expire.

Using POLST - Any incomplete section of POLST implies full treatment for that section.
Section A:
- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "No CPR. Do Not Attempt Resuscitation"

Section B:
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort-Focused Treatment", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment."
- A person who desires IV fluids should indicate "Selective Treatment" or "Full Treatment."

Section C:
- A patient or a legally authorized representative may make decisions regarding artificial nutrition or hydration. However, a surrogate who has not been designated by the patient (surrogate selected by consensus of interested persons) may only make a decision to withhold or withdraw artificial nutrition and hydration when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future. HRS §327E-5.

Reviewing POLST - It is recommended that POLST be reviewed periodically. Review is recommended when:
- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

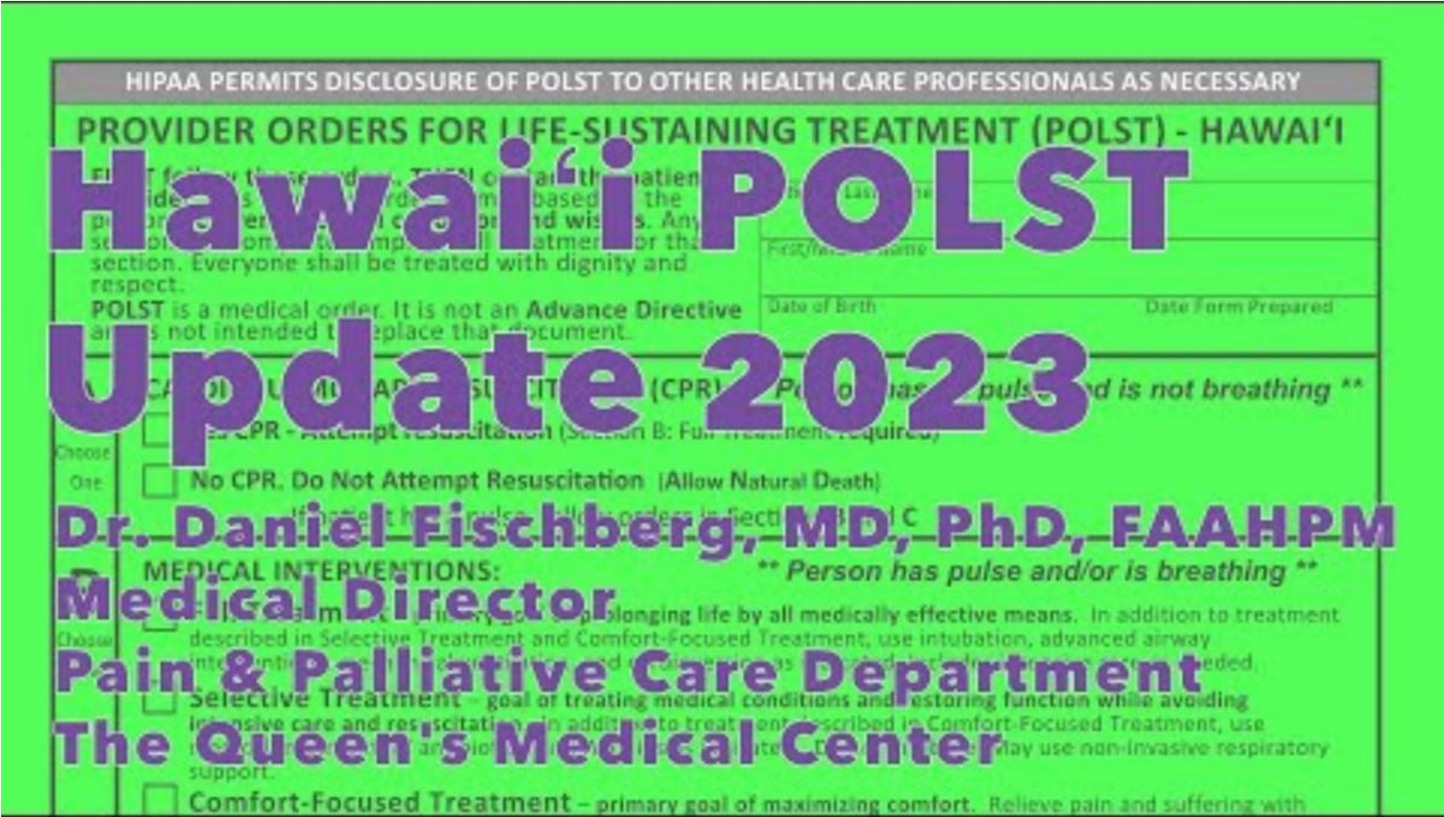
Modifying and Voiding POLST
- A person with capacity or, if lacking capacity the legally authorized representative, can request a different treatment plan and may revoke the POLST at any time and in any manner that communicates an intention as to this change.
- To void or modify a POLST form, draw a line through Sections A through E and write "VOID" in large letters on the original and all copies. Sign and date this line. Complete a new POLST form indicating the modifications.
- The patient's provider may medically evaluate the patient and recommend new orders based on the patient's current health status and goals of care.

Kōkua Mau - A Movement to Improve Care
Kōkua Mau is the lead agency for implementation of POLST in Hawai'i. Visit **kokuamau.org/polst** to download a copy or find more POLST information. This form has been adopted by the Department of Health May 2023
Kōkua Mau • PO Box 62155 • Honolulu HI 96839 • info@kokuamau.org • kokuamau.org

SEND THIS 2-PAGE FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED POLST pg 2 of 2

KŌKUA MAU
Continuous Care
A Movement to Improve Care

POLST changes in 2023



https://youtu.be/-NSupQGZU8o?si=2ZtNau_XjVY85t6s

Kōkua Mau
Continuous Care
A Movement to Improve Care

KŌKUA MAU
Continuous Care
A Movement to Improve Care

What is POLST?

- Provides direction for healthcare providers during serious illness.
- Allows for "shades of gray" in choices e.g. CCO-DNR bracelet is only "yes/no" choice
- Portable document that transfers with the patient
- Brightly colored, standardized form for entire state of HI

Who Would Benefit from Having a POLST Form?

- Chronic, progressive illness
- Serious health condition
- Medically frail
- A person for whom you would issue an in-patient DNR order
- "Would you be surprised if this patient died within the next year?"

Kōkua Mau
Continuous Care
A Movement to Improve Care

POLST in Hawaii

- Kōkua Mau is lead agency
- Grassroots efforts of local providers throughout the state
- Form and resources available at **www.Kokuamau.org**
- Allowed to become law July 15, 2009
- Legal changes in 2014

  - "Provider's" Orders: Expanded to allow APRN to sign the order

Legal changes in 2023: Physician Assistants can now sign as a provider

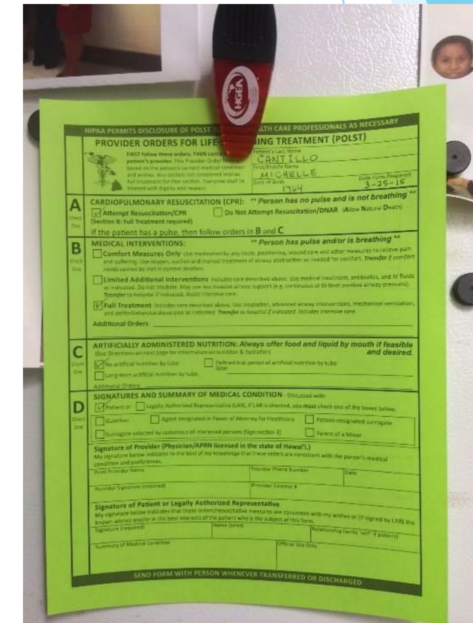
Diagram of POLST Medical Interventions

*Consider time/prognosis factors under "Full Treatment"

"Defined trial period. Do not keep on prolonged life support."

Practical considerations

- Recommended to be printed on **lime green** paper (but any color, including black and white is acceptable)
- A copy of the POLST form is legal
- Recommended to be kept in a visible place at home:
  - Refrigerator
  - Bedroom door
  - Bedside table
  - Medicine cabinet
- A copy should be given to EMS personnel
- POLST is not transferable from state to state

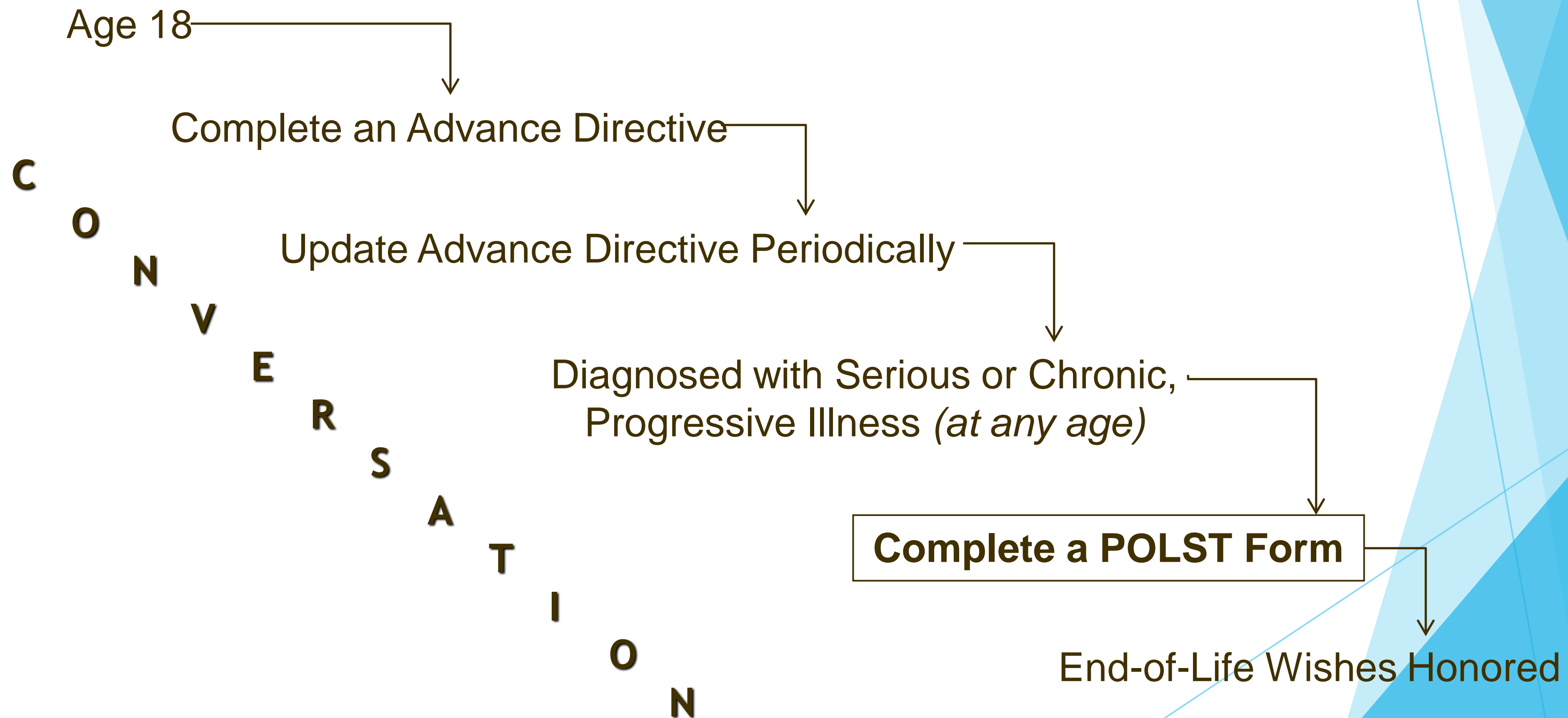


Kōkua Mau
Continuous Care
A Movement to Improve Care

Advance Health Care Directive vs. POLST

Advance Directives	POLST
For anyone 18 years or older	Persons at any age with serious illness
Identifies wishes for **future** healthcare	Indicates decisions about **current** treatments
Appoints a health care representative	Legally authorized representative can be noted
Does not translate into orders for EMS personnel	Actionable orders
CPR/DNR not addressed	CPR/DNR order

Where Does POLST Fit In?



Reviewing POLST

- Review whenever clinical condition changes
- Review when goals for therapy change
- Review at hospitalizations or if Code status changes in hospital
- ***Best way to communicate patient wishes to EMS***

Kōkua Mau
Continuous Care
A Movement to Improve Care

POLST: Depth of the Process

- POLST is more than a form.
- POLST:
  - Facilitates rich conversations with patients/families.
  - Complements the AHCD.
  - Incorporates the depth of comfort care.

KŌKUA MAU
Continuous Care
A Movement to Improve Care

Can POLST be Changed?

- Individual with capacity can request alternative treatment or revoke a POLST at anytime.
- Legally recognized decision maker may request change based on condition change or new information regarding patient wishes.

Kōkua Mau
Continuous Care
A Movement to Improve Care

POLST Conversations

- Opportunity to increase awareness of different courses of action possible

- Introduce concept of Palliative Care and Hospice

- Change the question:

  “What’s the matter with me?”

  to

  “What matters TO me?

Kōkua Mau
Continuous Care
A Movement to Improve Care

The POLST Conversation

- POLST is <u>not</u> just a check-box form.
- The POLST conversation provides context for patients/families to:
  - Make informed choices.
  - Identify goals of treatment.

Would this patient be a candidate for Palliative Care?

Could this patient benefit from an early hospice referral?

Join Us at Kōkua Mau!!

KŌKUA MAU
Continuous Care
A Movement to Improve Care

Resources and other activities

- Join Kōkua Mau Mailing List
- Download materials from the Kōkua Mau Website – look for the Tool Kit
- Use the translations
- Request a speaker from Kōkua Mau's **Let's Talk Story** Program – We are ready to talk with your church or other group!