



**KŌKUA MAU**  
*“Continuous Care”*

**A Movement to  
Improve Care**

# Updates to POLST - 2023

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# 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

# 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


# 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 Resources


### A GUIDE TO ADVANCE CARE PLANNING: MAKING LIFE DECISIONS



**KOKUA MAU**  
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Hawaii's Hospice and Palliative Care Organization

Executive Office on Active Department of Health

### YOUR ADVANCE DIRECTIVE FOR FUTURE HEALTH CARE



It is your gift to loved ones, family members and friends so that they won't have to guess what you want if you no longer can speak for yourself

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### HAWAII ADVANCE HEALTH CARE DIRECTIVE

My name is \_\_\_\_\_ Date of Birth \_\_\_\_\_  
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 \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
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 \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
If I revoke my alternate agent's authority or if my alternate agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

Name \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_

AGENT'S AUTHORITY AND OBLIGATION:  
My health care agent should make decisions as I have expressed in Part 2 of this form as if I were still able to make such decisions or as I would have chosen to do, having taken into my values, faith, and preferences rather than those of my agent. It is the patient's duty to ensure that the agent is qualified to act by a court. I authorize my agent:

WHEN AGENT'S AUTHORITY BEGINS TO BE EFFECTIVE:  
My agent's authority begins to be effective when my primary physician determines that I am unable to make my own health care decisions as set forth in the following box:  
 I'll mark this box my agent's authority to make health care decisions for me takes effect immediately. However, I agree that the agent is to make any decision about my health care that I revoke the authority at any time as long as I have mental capacity.

PART 2: INDIVIDUAL INSTRUCTIONS (It may modify or make through writing with what I have said in Part 1.)

A. END OF LIFE DECISIONS  
\* I am an individual and competent person that will remain in my death with a relatively short life expectancy. I want my agent to communicate my wishes regarding my health care and to make sure I will never receive that ability.  
\* I do not want my agent to communicate my wishes regarding my health care and to make sure I will never receive that ability.  
\* I do not want my agent to communicate my wishes regarding my health care and to make sure I will never receive that ability.

B. LIFE SUPPORT  
\* I do not want my agent to communicate my wishes regarding my health care and to make sure I will never receive that ability.  
\* I do not want my agent to communicate my wishes regarding my health care and to make sure I will never receive that ability.  
\* I do not want my agent to communicate my wishes regarding my health care and to make sure I will never receive that ability.

C. ORGAN DONATION  
\* I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.  
\* I do not want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

Name and address your Advance Health Care document with your doctor, loved ones and agent Page 1 of 2

### Questions about CPR

Being asked to make a decision about cardiopulmonary resuscitation (CPR) can be complicated. Fear of not being seen CPR performed. Our understanding of CPR may come from what we see on TV, where a doctor says and seems to be very successful without any complications. Unfortunately, these TV images of CPR are not completely accurate.

This brochure provides answers to some common questions about what CPR involves and what life is important to think about when making a decision about CPR.

### Kokua Mau - Hawaii's Hospice and Palliative Care Organization

#### WHAT DOES CPR LOOK LIKE?

It's a longer process than most people realize. It's an attempt to restart the heart when the heart has stopped beating.

The person is placed on a hard board or on the ground and the carter of the chest is pushed in about 1.5 to 2 inches. These chest compressions must be done 100 times each minute. Artificial respiration using a special mask and bag over the person's mouth to pump air into the lungs may be started when the emergency team arrives, a breathing tube may be inserted into the windpipe to provide oxygen, and a number of electrical shocks may be given with paddles that are placed on the chest. An intravenous line (IV) will be placed in a vein and medication will be given through the IV line.

If the heart continues to respond to the emergency treatment, the person is taken to the emergency department. Those who survive will then be transferred to the intensive care unit at the hospital and attached to a ventilator (breathing machine) and a heart monitor. At the time, most persons are still unconscious.

#### WHO IS LEAST LIKELY TO BENEFIT FROM CPR?

Risk factors that are more frequent among older persons may contribute to lower chances of CPR survival age increases. Most older adults do not have the type of heart rhythm that responds to CPR. Having any chronic disease that affects the heart, lungs, brain or kidneys can lower chances for survival after cardiac arrest. If a person has multiple advanced chronic diseases, CPR survival will be low even.

Individuals in advanced stages of dementia have CPR survival rates three times lower than those without dementia. Several studies also looked at survival rates in nursing home residents in advanced stages of illness who were dependent on others for all of their care showed CPR survival rates of 0-5% even if they were transferred from the nursing home to the hospital before the cardiac arrest. Older adults in terminal stages of cancer had CPR survival rates = 1%.

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### A GUIDE FOR DECISION MAKING

### Tube Feeding

"I've been asked to decide about a feeding tube."

Making a decision about a long-term feeding tube for yourself or for someone you love may be challenging and emotional. Those who have faced a similar decision have told us that writing honest answers to their questions was most helpful.

HOWEVER, every situation is different. What might help someone with a short-term comfortable feeding problem may not be best for long-term use or someone with advanced illness or age.

### Kokua Mau - Hawaii's Hospice and Palliative Care Organization

#### What is tube feeding used for?

Medical nutrition and hydration is a way of giving liquid and nutrients to people who cannot eat or drink by mouth. Usually, to avoid more artificial nutrition and hydration, enteral tube feeding is recommended as "tube" (also) put through the person's nose and taped to the side into the stomach, for long-term artificial nutrition and hydration, a tube may be put directly through the side into the stomach, called a gastric or "G" tube or PEG tube. Percutaneous Endoscopic Gastrostomy or the stoma (called a stoma or "T" tube). Sometimes fluids are given through a vein (IV).

#### When are feeding tubes less helpful?

When individuals have the ability to swallow or eat without assistance. If an individual's progressive disease (such as dementia, stroke, Parkinson's, Alzheimer's, etc.) is such that the person is unable to eat or drink, then a feeding tube may be helpful. However, if the person does not seem to be interested in eating or drinking, or if the person does not seem to be interested in eating or drinking, then a feeding tube may not be helpful.

#### Who is helped most by having a feeding tube?

Some people fear that not providing a feeding tube means they are letting their loved one "starve to death." This is not true. Starvation occurs when a person whose body needs and can use the nutrients in a diet of food. When a person's body begins to shut down, they may be physically unable to eat/drink, or unable to take food/feeding orally. Feeding tubes, and the chance of bleeding and discomfort involved.

#### Will my loved one starve?

Some people fear that not providing a feeding tube means they are letting their loved one "starve to death." This is not true. Starvation occurs when a person whose body needs and can use the nutrients in a diet of food. When a person's body begins to shut down, they may be physically unable to eat/drink, or unable to take food/feeding orally. Feeding tubes, and the chance of bleeding and discomfort involved.

### A GUIDE FOR DECISION MAKING

### HAWAII PERMITS "DECLINE OF POLST" TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

#### PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

THESE POLST orders allow your doctor, nurse, or other health care provider to know your wishes about life-sustaining treatment. They are used to guide your care when you are unable to speak for yourself.

**A**  Attempt Resuscitation (CPR)  Do Not Attempt Resuscitation (DNAR) (Also known as DNR)  
(Decisions for Treatment requests)  
If the patient has a POLST, they follow orders in **B** and **C**.

**B**  Comfort Measures Only  Person has *choice* and/or *is breathing*  
If the patient has a POLST, they follow orders in **B** and **C**.  
\* Limited Additional Interventions: Interventions described below, the medical assistant, nurse, and/or family member may provide. Make sure the patient or caregiver understands the purpose of the intervention and that the patient or caregiver is willing to accept the intervention.  
\* Full Treatment: Interventions described above, the intervention, advanced care instructions, medical certification and other information requested, please to hospital/caregiver, receive intervention.

**C**  Artificially Administered Nutrition: Always offer food and liquid by mouth if possible  
\* If artificial nutrition by tube  Artificially Administered Hydration: Always offer fluids by mouth if possible  
\* If artificial hydration by tube  Long-term artificial nutrition by tube  Long-term artificial hydration by tube

**D** SIGNATURES AND SUMMARY OF MEDICAL CONDITION (Required with POLST)  
\* Patient or  Legally Authorized Representative (LAR) (LAR is designated on the back of this form)  
\* Provider  Agent designated in Power of Attorney for Health Care  Patient designated surrogate  
\* Hospital admission (admission of interested persons) (Sign on back)  Patient of a Minor  
\* Signature of Provider (Physician/ARNP/Nurse) (to be filed in the state of Hawaii)  
\* Signature of Patient or Legally Authorized Representative (to be filed in the state of Hawaii)  
\* Signature of Hospital Admission (to be filed in the state of Hawaii)  
\* Signature of Patient or Legally Authorized Representative (to be filed in the state of Hawaii)

**SEND FORM WITH PERSON WHOEVER TRANSPORTS OR DISCHARGES**

### A Provider's Guide to POLST

(Provider Orders for Life-Sustaining Treatment) Maintained for Hawaii by Kōkua Mau

#### What is POLST?

POLST (Provider Orders for Life-Sustaining Treatment) is a medical order that gives patients more control over their end-of-life care. It specifies the types of treatments that a patient wishes to receive towards the end of life. Completing a POLST form encourages communication between healthcare providers and patients, enabling patients to make informed decisions. The POLST form documents these decisions in a clear manner and can be quickly understood by all providers, including first responders and emergency medical services (EMS) personnel. As a result, the patient's wishes are less likely to be overridden.

Is the POLST simply a DNR order?  
No. POLST is a document that empowers a patient or their legally authorized representative (see below) to make decisions through the wishes of the patient or their legally authorized representative, the attending care, the patient's own wish, including, but not limited to, resuscitation or do not attempt resuscitation.

Is POLST the same as an Advance Health Care Directive?  
No. POLST does not replace an Advance Health Care Directive (AHCD). The AHCD can provide significant detail about an individual's wishes and preferences for treatment. In addition, the AHCD is the most common mechanism for designating a legally authorized representative decision maker for the patient.

Will the CCC-DNR bracket still be honored by EMS?  
Yes. The CCC-DNR bracket is still a valid medical order to communicate a person's intent about attempts to resuscitate. There are still thousands of these brackets in use, and EMS personnel will continue to honor this directive.

Who is the POLST form line green?  
The POLST form is usually completed on a distinctive single line-green form, but is also freely available from the internet at [www.kokuamau.org/polst](http://www.kokuamau.org/polst) and is acceptable in black and white. The bright green color is to make the form quickly visible to hospitals and emergency medical services personnel. The line-green color is also each copier. A copy on white paper is a valid document.

Does the POLST form travel with the patient between settings of care?  
Yes. The POLST form is designed to be a standard form that may be accepted by all providers across the state. As a legal medical order, it will be honored by EMS, hospitals, long-term care facilities, home care and hospice providers who will voluntarily honor the form and include it into their medical records. However, providers with electronic medical records may choose to adopt the essence of the order into their specific system. Hospice discharge planners are encouraged to support the completion of the POLST form (when clinically appropriate) as a part of their daily practice.

Is implementing the orders from the POLST form protected under Hawaii's Law?  
Yes. The law states that no provider will be held liable for criminal prosecution or civil liability for failing to follow the treatment orders in good faith or for performing cardiopulmonary resuscitation if the person performing CPR was unaware of the POLST form unless the person resuscitated or they witness that the treatment orders (including the POLST form) had been revoked or cancelled.

How do providers get more copies of the POLST form?  
The POLST form is available from the internet at [www.kokuamau.org/polst](http://www.kokuamau.org/polst) or by mail from the Kokua Mau office. The form may be obtained by mail from the Kokua Mau office. The form may be obtained by mail from the Kokua Mau office. The form may be obtained by mail from the Kokua Mau office.

Where is the Family encouraged to keep the form?  
For the patient home, the POLST form should be kept in a place readily accessible by family members. Examples include the refrigerator, in the medicine cabinet, on the back of a bedroom door or on a bedside table. It should be kept with the AHCD.

Page 1 of 2 - A Provider's Guide to POLST - Provided by Kōkua Mau on July 2016 at [www.kokuamau.org/technicalsupport](http://www.kokuamau.org/technicalsupport)

### What is POLST?

Provider Orders for Life-Sustaining Treatment  
A Consumer Guide to POLST  
Maintained for Hawaii by Kōkua Mau

**POLST - Provider Orders for Life-Sustaining Treatment**, is your care wishes carried out through:  
\* Your medical orders, completed by a doctor or an advanced practice registered nurse (APRN)  
\* It followed by health care providers, including Emergency Medical Services, such as Paramedics.  
\* You POLST when you have a serious health condition.  
\* Social workers, nurses and other healthcare professionals can help you fill out your POLST form, but you must be signed by your physician or APRN or other person you select.  
\* POLST contains medical orders indicating what medical care you want or don't want if you become unable to make the decisions yourself.  
\* Your doctor or APRN, who is licensed in the State of Hawaii (or allowed to practice from the military or VA) MUST review and sign the POLST form.  
\* POLST also requires your signature or that of your Legally Authorized Representative (see page 2 for definition).

When would I need a POLST form?  
\* The POLST form is intended for a person who has a chronic debilitating illness or is facing a life limiting disease, such as end-stage lung or heart disease or terminal cancer.  
\* The decision to create a POLST should be discussed with each person's own provider.

The POLST form asks for information about your preferences for medical treatments:  
\* Whether to attempt cardiopulmonary resuscitation or not (see results for "Questions about CPR").  
\* The intensity of medical care you want.  
\* If you want to be hospitalized and under what conditions, and.  
\* If you want artificial nutrition by medicine tube (see Kōkua Mau website for "Tube Feeding" handout).

**FREQUENTLY ASKED QUESTIONS (FAQ)**

How do I get a copy of the POLST form?  
You or your provider can download POLST form and instructions for your doctor at the Kōkua Mau website: [www.kokuamau.org/polst](http://www.kokuamau.org/polst). The Kōkua Mau website is the central source for POLST information for Hawaii. Most hospice, nursing homes, home health and hospice providers as well as others in the community also have the form for you, and you can also obtain the form and instructions by mail. Please remember that your POLST form must be signed by your doctor or Advanced Practice Registered Nurse (APRN) to be valid.

Does the law require that I complete a POLST form?  
No. POLST is voluntary and has been available in Hawaii since July 2009. However, without a POLST, Emergency Medical Services (EMS) will have medical orders to attempt to resuscitate to return you home, unless you are already dead, even if you do not want an attempt to be made to resuscitate you, and would prefer to die a natural death.

Where is the POLST form kept?  
If you live at home you should keep the original line green POLST form in a location where it can easily be seen. The ideal place is your refrigerator where EMS personnel will look for it first. Other visible places could be the back of a bedroom door, on a bedside table, or in your medicine cabinet. If you reside in a long-term facility, your POLST form may be kept in your resident care bag along with other medical orders. A copy of the POLST form on white paper is legal.

Page 1 of 2 - A Consumer Guide to POLST - Provided by Kōkua Mau on July 2016, at [www.kokuamau.org/polst](http://www.kokuamau.org/polst)

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 Hawaii
- Chinese traditional POLST Form for Hawaii
- Ilocano POLST Form for Hawaii
- Japanese POLST Form for Hawaii
- Korean POLST Form for Hawaii
- Marshallese POLST Form for Hawaii
- Spanish POLST Form for Hawaii
- Tagalog POLST Form for Hawaii
- Tongan POLST Form for Hawaii
- Vietnamese POLST Form for Hawaii

# 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



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# Advance Health Care Directive



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**HAWAII 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 2

Available to download on Kōkua Mau Website: [www.Kokuamau.org](http://www.Kokuamau.org)



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

## 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

- ▶ 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



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

**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

# 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”



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# 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.)



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

- ▶ 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):

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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:**



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**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 CARDIOPULMONARY RESUSCITATION (CPR): *\*\* Person has no pulse and is not breathing \*\****  
Check One:  Attempt Resuscitation/CPR  Do Not Attempt Resuscitation/DNAR (Allow Natural Death)  
*(Section B: Full Treatment required)*  
If the patient has a pulse, then follow orders in B and C.

**B MEDICAL INTERVENTIONS: *\*\* Person has pulse and/or is breathing \*\****  
Check One:  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 ARTIFICIALLY ADMINISTERED NUTRITION: *Always offer food and liquid by mouth if feasible and desired.***  
*(See Directions on next page for information on nutrition & hydration)*  
Check One:  No artificial nutrition by tube.  Defined trial period of artificial nutrition by tube. *Goal:* \_\_\_\_\_  
 Long term artificial nutrition by tube.  
Additional Orders: \_\_\_\_\_

**D SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:**  
Check One:  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 Hawaii.)**  
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.  
First/Last Name: \_\_\_\_\_ Provider Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_  
Provider Signature (required): \_\_\_\_\_ Provider License #: \_\_\_\_\_  
**Signature of Patient or Legally Authorized Representative**  
My signature below indicates that these orders of 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



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# 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) - HAWAII**

**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.

|            |  |
|------------|--|
| Choose One | <input type="checkbox"/> <b>A</b> CARDIOPULMONARY RESUSCITATION (CPR): <b>** Person has no pulse and is not breathing **</b><br><input type="checkbox"/> Yes CPR - Attempt resuscitation (Section B: Full Treatment required)<br><input type="checkbox"/> No CPR. Do Not Attempt Resuscitation (Allow Natural Death)<br>If patient has a pulse, follow orders in Sections B and C.   |
| Choose One | <b>B</b> MEDICAL INTERVENTIONS: <b>** Person has pulse and/or is breathing **</b><br><input type="checkbox"/> 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.<br><input type="checkbox"/> 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.<br><input type="checkbox"/> 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.<br>Additional Orders:  |
| Choose One | <b>C</b> ARTIFICIALLY ADMINISTERED NUTRITION: <b>Always offer food and liquid by mouth if feasible and desired.</b><br>(See Directions on next page for information on nutrition & hydration)<br><input type="checkbox"/> No artificial nutrition by tube <input type="checkbox"/> Defined trial period of artificial nutrition by tube<br><input type="checkbox"/> Long-term artificial nutrition by tube<br>Goal:<br>Additional Orders:  |
| Choose One | <b>D</b> SIGNATURES AND SUMMARY OF MEDICAL CONDITION Discussed with:<br><input type="checkbox"/> Patient or <input type="checkbox"/> Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below:<br><input type="checkbox"/> Guardian <input type="checkbox"/> Agent designated in Power of Attorney for Healthcare <input type="checkbox"/> Patient-designated surrogate<br><input type="checkbox"/> Surrogate selected by consensus of interested persons (Sign section E) <input type="checkbox"/> Parent of a Minor<br>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.<br>Signature (required) Name (print) Relationship (write "self" if patient)<br>Signature of Provider (Physician/APRN/PA licensed in the state of Hawaii). My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.<br>Print Provider Name Provider Phone Number Date<br>Provider Signature (required) Provider License #<br>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**

|            |  |
|------------|--|
| Choose One | <b>E</b> SURROGATE SELECTED BY CONSENSUS OF INTERESTED PERSONS (Legally Authorized Representative as outlined in section D)<br>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 Hawaii 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.<br>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 Hawaii 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.

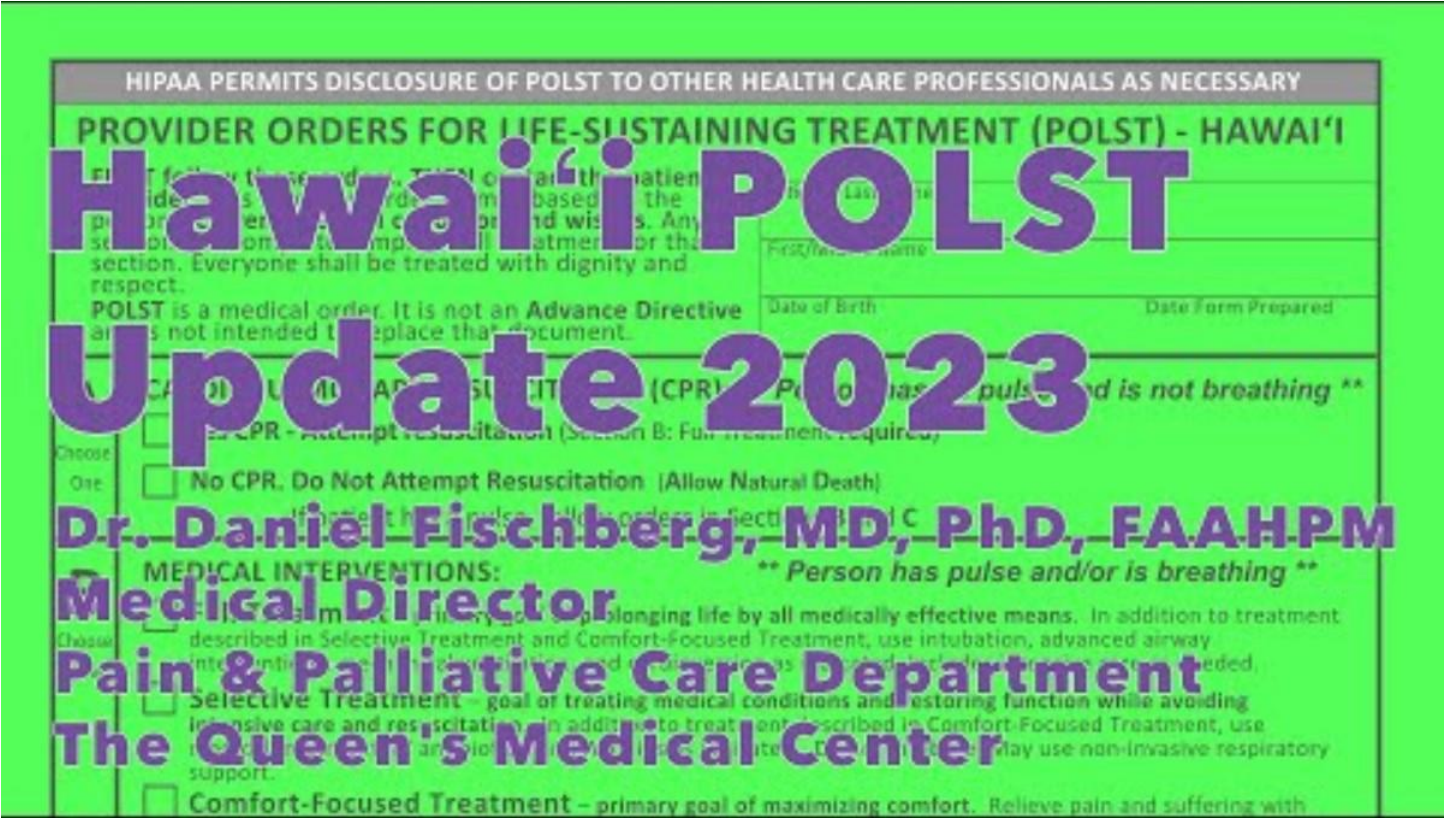
**Kōkua Mau - A Movement to Improve Care**  
Kōkua Mau is the lead agency for implementation of POLST in Hawaii. Visit [koku mau.org/polst](http://koku mau.org/polst) to download a copy or find more POLST information. This form has been adopted by the Department of Health May 2023.  
Kōkua Mau • PO Box 62125 • Honolulu, HI 96869 • [info@koku mau.org](mailto:info@koku mau.org) • [koku mau.org](http://koku mau.org)

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# POLST changes in 2023



[https://youtu.be/-NSupQGZU8o?si=2ZtNau\\_XjVY85t6s](https://youtu.be/-NSupQGZU8o?si=2ZtNau_XjVY85t6s)



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# 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?”



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# POLST in Hawaii

- Kōkua Mau is lead agency
- Grassroots efforts of local providers throughout the state
- Form and resources available at [www.Kokuamau.org](http://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*



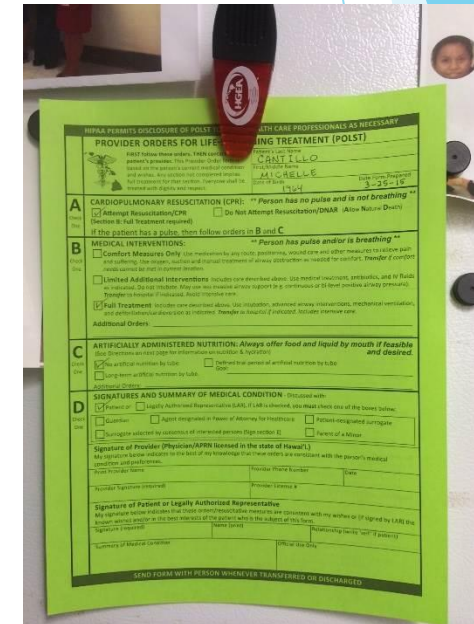
# Diagram of POLST Medical Interventions



*\*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



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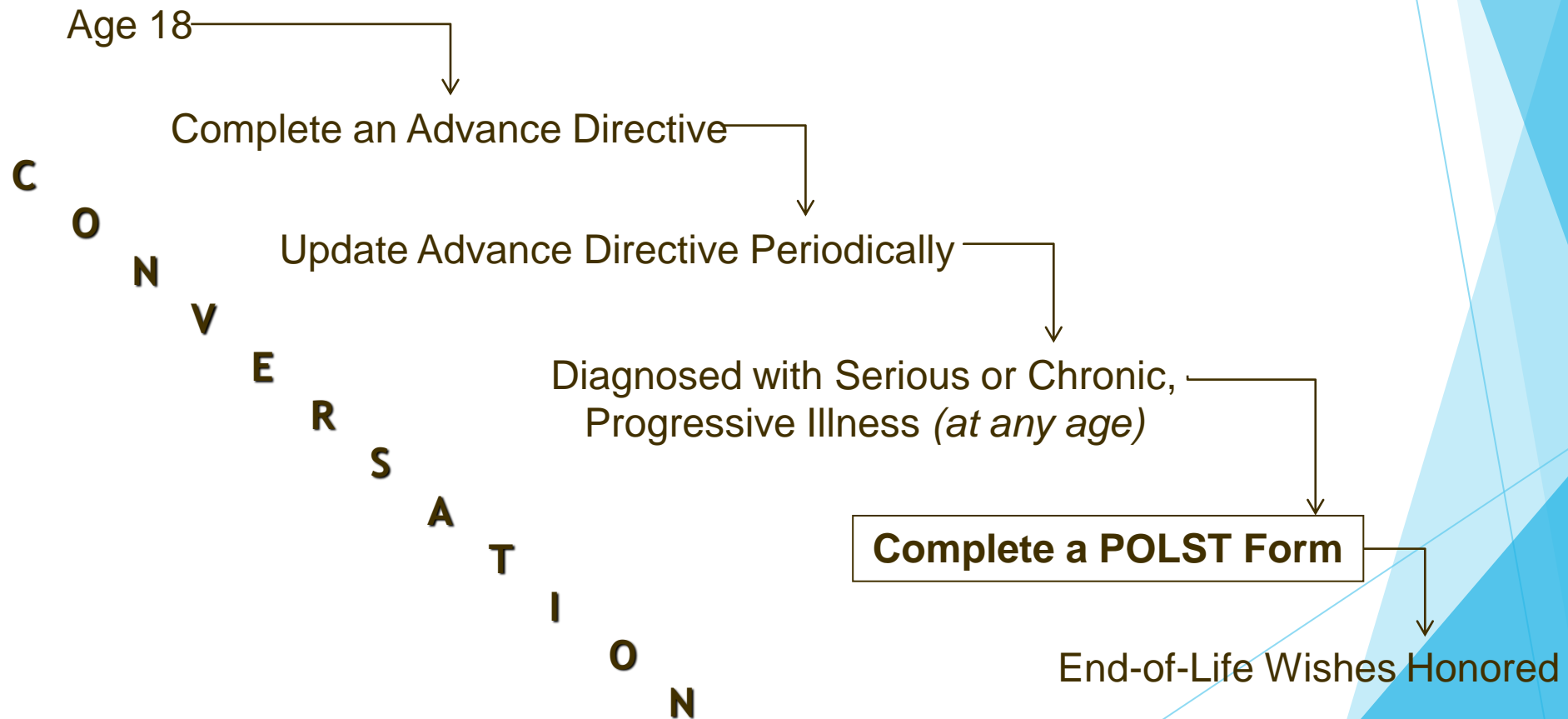


# Advance Health Care Directive vs. POLST

| <b>Advance Directives</b>                        | <b>POLST</b>  |
|--|---|
| For anyone 18 years or older                     | Persons at any age with serious illness             |
| Identifies wishes for <b>future</b> healthcare   | Indicates decisions about <b>current</b> 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?

## *Advance Care Planning Continuum*





# 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***



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# 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.



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# 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.



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# 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?”



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# The POLST Conversation

- POLST is not 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!!



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## 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!