

- ✓ **Community of Learning**
- ✓ **Confidential Case Sharing**
- ✓ **Practical**



- ✓ **Interdisciplinary**
- ✓ **On-line Learning**
- ✓ **Free CME and CE**

Learn and apply Leadership & Quality Improvement principles from experts!

Share and get practical tips from colleagues!

Project ECHO University of Hawaii

Long-Term Care Learning Action Network

A Collaborative Partnership
to Provide Education from
Quality Improvement and
Leadership and
Implementation Experts
with Case Discussion to
build a Community of
Learning



Long-Term Care Learning Action Network



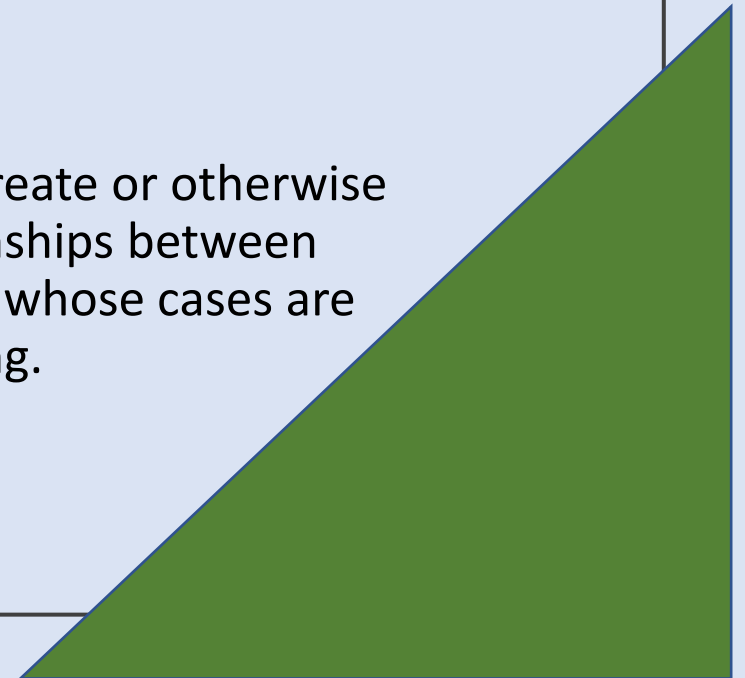
This series is made possible through GWEP funding to the University of Hawaii Department of Geriatric Medicine from the Health Resources and Services Administration (HRSA): Grant Nos. U1QHP28729 and T1MHP39046 and the support from generous our donors- AlohaCare and UnitedHealthcare

Confidential & Safe



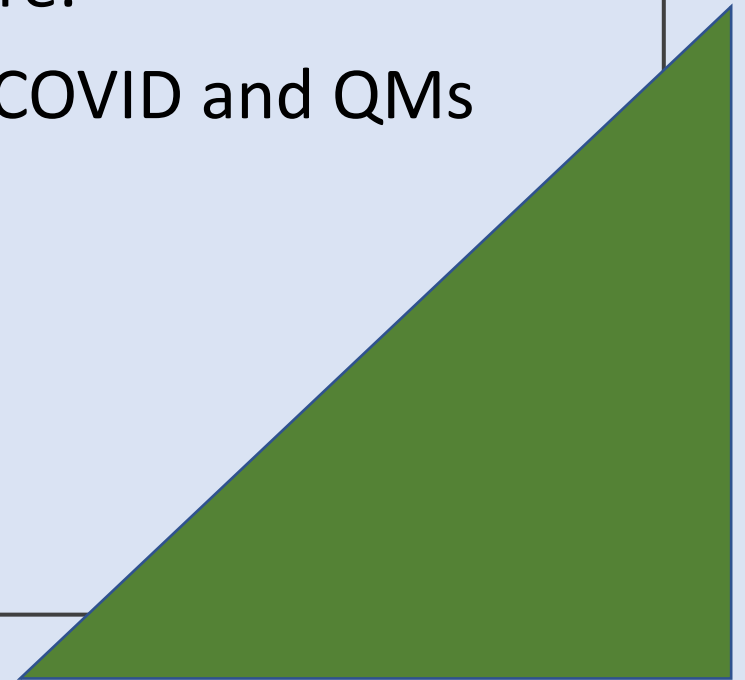
We commit to maintain and safeguard the **confidentiality of information** shared. All case presentations are required to be de-identified and **HIPAA compliant**. In order to create a **safe learning environment**, we will foster a culture of mutual learning and **encouragement**, rather than negativity, shame and blame.

ECHO case consultations do not create or otherwise establish provider-patient relationships between any ECHO specialists and patients whose cases are being presented in an ECHO setting.



Learning Objectives

- Explore strategies for well-being during the Pandemic and recovery
- Practice Age Friendly Health Systems strategies
- Identify QI strategies to improve nursing home care.
- Increased knowledge for regulatory guidance for COVID and QMs



CME Credits

In order to receive CMEs please:

1. Register:

<https://echo.zoom.us/meeting/register/tJUqcuysrjsvGtE2kdnnVk9kl4iAu9cPoOGB>

2. Complete an Evaluation

<https://geriatrics.jabsom.hawaii.edu/nh-echo-lan/>

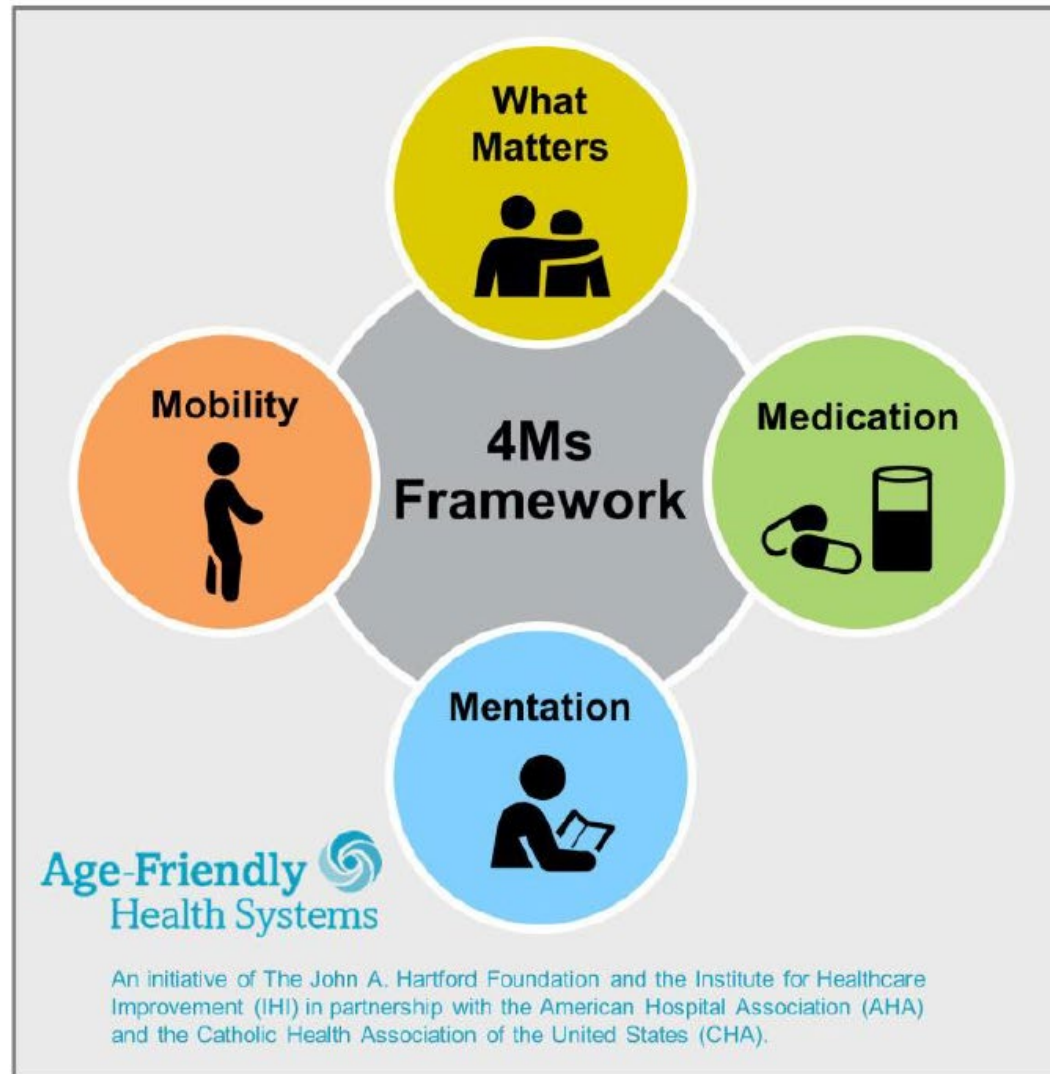
** Some systems do not allow access to google forms. Fillable PDFs can be found on our website. Please send to Jon at Nakasone@hawaii.edu

The Hawaii Consortium for **Continuing Medical Education** is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

This program is approved by the **National Association of Social Workers** - Hawai'i Chapter (Approval HI62792021-190) for up to 1 Social Work continuing education contact hour(s).

If you would like
to get
AFHS
Recognition
from IHI
for providing
comprehensive
geriatric care at
your Nursing
Facility, we can
help you.

Figure 1. 4Ms Framework of an Age-Friendly Health System



For related work, this graphic may be used in its entirety without requesting permission.
Graphic files and guidance at ihi.org/AgeFriendly

What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

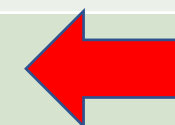
Stay tuned...

What Matters Series- 4 Parts

LTC ECHO LAN Schedule

2nd Tuesday of each
month
2:00- 3:00 pm

DATE	TOPIC
Feb	Who Knows What Matters?
Mar	Understanding What Matters
Apr	Addressing What Matters
May	Care Plans that Matter



** Session Topics subject to change

Introducing: The Hub Team

	Position	Role
Aida Wen, MD, CMD	UH Dept of Geriatric Medicine	Course Director
Hope Young	Kokua Mau	Speaker
Gayle Rodrigues, MSN, RN	Director of Nursing, Oahu Care Facility	Facilitator
Dana Mitchell, RN	Mountain Pacific Quality Health	QI Coach
Lori Henning, LNHA	HAH-Quality & Education Program	COVID and Regulatory updates

*Our speakers report that they have no conflicts of interest.

Wellness

1. *Rest*
2. *Restore*
3. *Create*
4. *Connect*

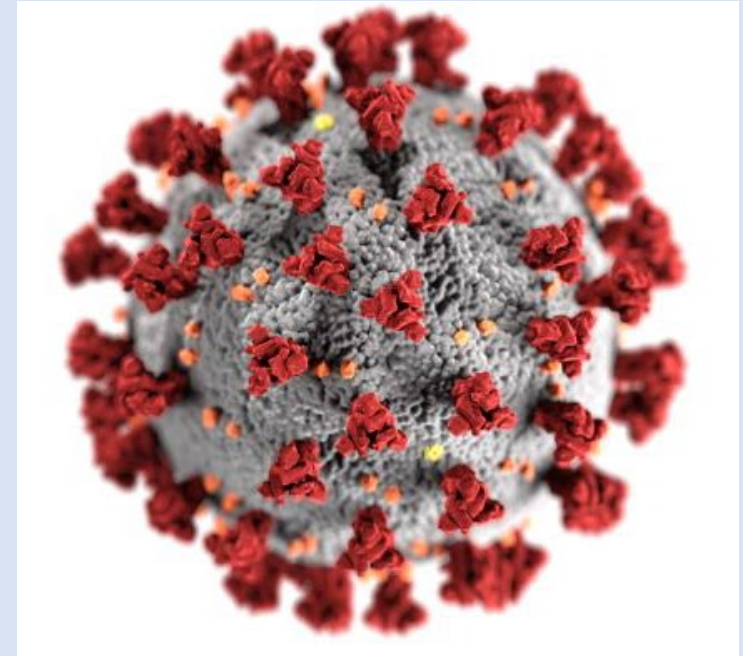


These are important to put back into your life – DO IT THIS WEEK!



Regulatory & COVID-19 Updates

Healthcare Association of Hawaii



What Matters Series – Part 3

Addressing What Matters Most

Documenting the Conversation



Let's Talk Story!!

Kokua Mau's Let's Talk Story Program

Advance Directives and POLST

Hope Young

Advance Care Planning Coordinator

Advance Care Planning

Why is it important?

- No one knows when they may become “Very ill”
- Helps companions to find their voice
- Helps prepare them and their family for what’s coming
- Ease the burden for others having to make tough choices
- Helps assure their wishes are followed
- COVID 19 has changed the way health care is provided



KŌKUA MAU
Continuous Care

A Movement to Improve Care



“I’m not afraid of death; I
just don’t want to be there
when it happens.”

~Woody Allen

If the unexpected happened,



Who would speak for you?

Would they know what you would want?

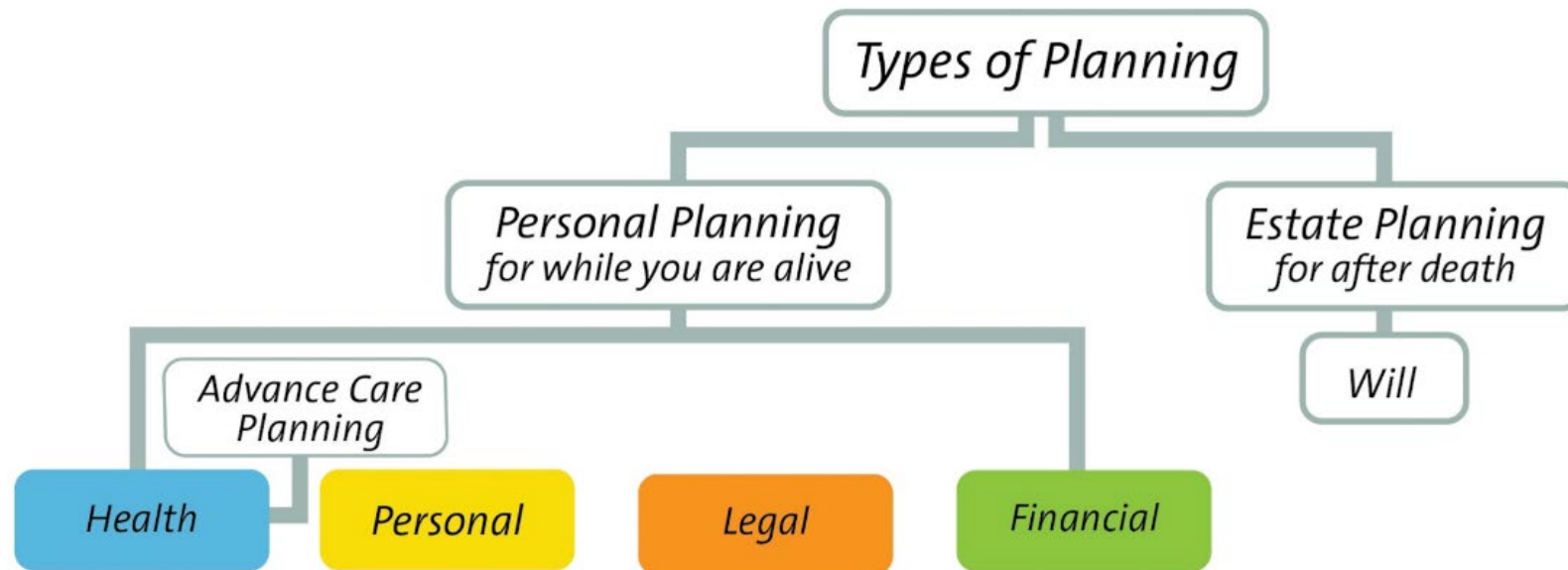


Or possibly what you would not want?

Did you know...

- Everyone over the age of 18 should have an Advance Health Care Directive (AD or AHCD) which appoints a Health Care Agent
- Without an AD, precious time could be spent trying to designate a Health Care Agent from “interested parties”, there is no next-of-kin hierarchy in the state of Hawaii. If the “interested parties” cannot come to an agreement, it could become a guardianship case, which could take 6 months to resolve

Cover all your bases!



Source: Nidus Personal Planning Resource Centre and Registry

Advance Health Care Directive

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 3**

Available to download on Kokua Mau Website www.kokuamau.org

Advance Health Care Directive (AHCD)

- Legal document completed only when you are of sound mind



- Appoints a Health Care Power of Attorney (s)
- State instructions for future choices on your end of life decisions

AHCD – Part 1:

Health Care Power of Attorney (HCPOA)

- 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

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

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”

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.)

Artificial Nutrition and Hydration: Important considerations

- Individual and personal decision.
- In some illnesses (e.g. stroke, esophageal/ throat cancer) artificial nutrition can prolong life.
- In others (Parkinson's, dementia, terminal cancer) artificial nutrition may not prolong life.

Section C & D: Relief of Pain and Other Important considerations

- Pain medications to ensure comfort at the end of life can hasten death.
- This is considered ethically acceptable by most medical professionals to provide comfort.
- Again, this is a personal and individual decision.

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.)

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):

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 CARDIOPULMONARY RESUSCITATION (CPR): ** Person has no pulse and is not breathing **
Check One: ☐ 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 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.
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 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

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?”

POLST in Hawaii

- One form for entire state.
- Use **not** mandated.
- **Honoring form is mandated.**
- Provides immunity from civil or criminal liability.


POLST in Hawaii

Effective 2009, Updated 2014

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY	
PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)	
<small>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.</small>	
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 ** <input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> 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 Check One	MEDICAL INTERVENTIONS: ** Person has pulse and/or is breathing ** <input type="checkbox"/> 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. <i>Transfer if comfort needs cannot be met in current location.</i> <input type="checkbox"/> 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). <i>Transfer to hospital if indicated. Avoid intensive care.</i> <input type="checkbox"/> Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. <i>Transfer to hospital if indicated. Includes intensive care.</i> Additional Orders:
C Check One	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Always offer food and liquid by mouth if feasible and desired.</i> (See Directions on next page for information on nutrition & hydration) <input type="checkbox"/> No artificial nutrition by tube. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. Goal: <input type="checkbox"/> Long-term artificial nutrition by tube. Additional Orders:
D Check One	SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with: <input type="checkbox"/> Patient or <input type="checkbox"/> Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below: <input type="checkbox"/> Guardian <input type="checkbox"/> Agent designated in Power of Attorney for Healthcare <input type="checkbox"/> Patient-designated surrogate <input type="checkbox"/> Surrogate selected by consensus of interested persons (Sign section E) <input type="checkbox"/> Parent of a Minor Signature of Provider (Physician/APRN licensed in the state of Hawai'i) My signature below indicates that 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	

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY	
Patient Name (Last, First, middle)	
Date of Birth	Gender M F
Patient's Preferred Emergency Contact or Legally Authorized Representative	
Name	Address
Phone Number	
Health Care Professional Preparing Form	Preparer Title
Phone Number	Date Form Prepared
E Check One	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 or Advanced Practice Registered Nurse (APRN) 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.	
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 "Do Not Attempt Resuscitation." Section B: • When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," 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 Measures Only." • A person who desires IV fluids should indicate "Limited Interventions" 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 – Hawai'i Hospice and Palliative Care Organization Kōkua Mau is the lead agency for implementation of POLST in Hawai'i. Visit www.kokumau.org/polst to download a copy or find more POLST information. This form has been adopted by the Department of Health July 2014. Kōkua Mau • PO Box 62155 • Honolulu HI 96829 • info@kokumau.org • www.kokumau.org	
SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED	

HI POLST Form – Information

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

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			
Patient Name (last, first, middle)		Date of Birth	Gender M F
Patient's Preferred Emergency Contact or Legally Authorized Representative			
Name	Address	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Form Prepared

Section A: Cardiopulmonary Resuscitation (CPR)

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

*****Person has no pulse and is not breathing*****

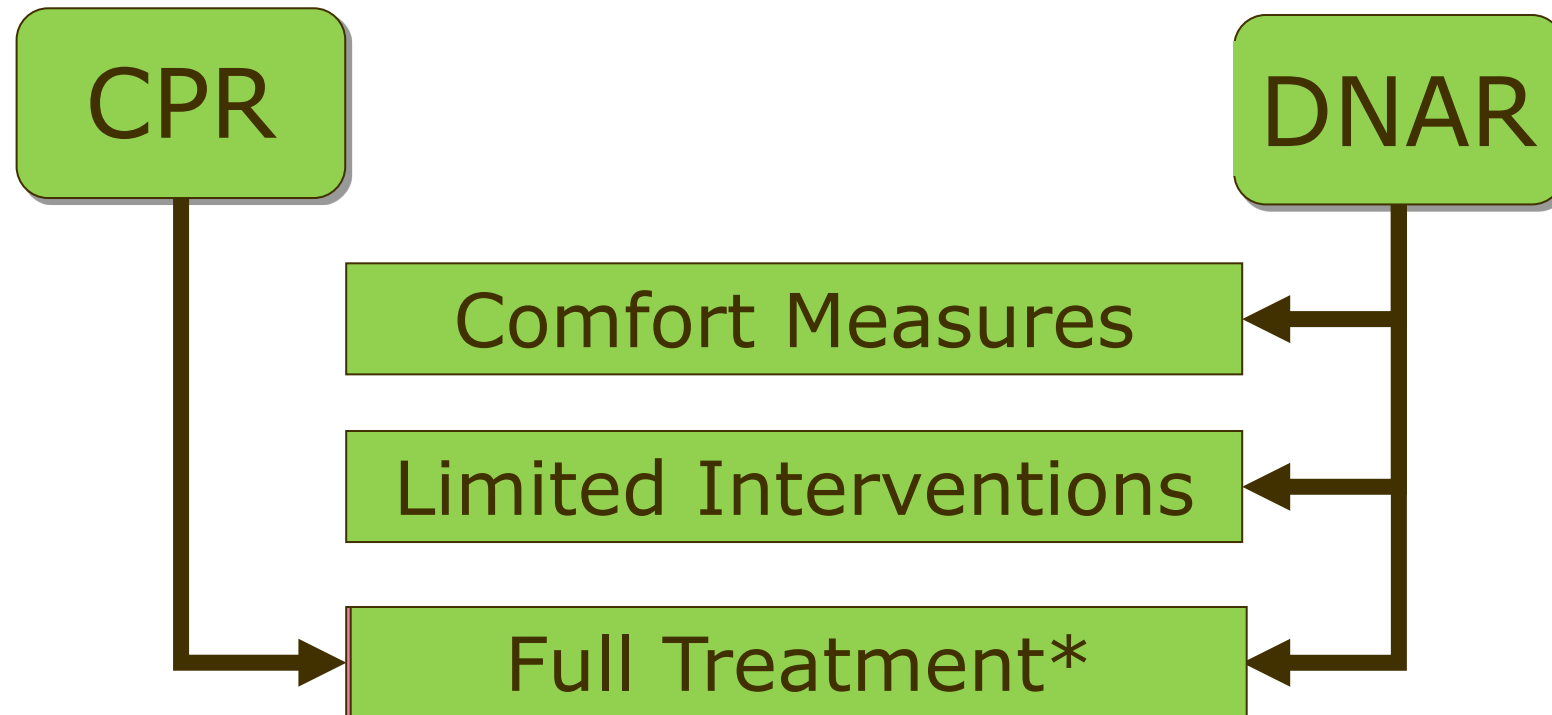
Section B:

Medical Interventions

B Check One	MEDICAL INTERVENTIONS:	<i>** Person has pulse and/or is breathing **</i>
	<input type="checkbox"/> 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. <i>Transfer if comfort needs cannot be met in current location.</i>	
	<input type="checkbox"/> 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). <i>Transfer to hospital if indicated. Avoid intensive care.</i>	
	<input type="checkbox"/> Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. <i>Transfer to hospital if indicated. Includes intensive care.</i>	
Additional Orders: _____		

*****Person has pulse and/or is breathing*****

Diagram of POLST Medical Interventions



*Consider time/prognosis factors under "Full Treatment"
"Defined trial period. Do not keep on prolonged life support."

Section C: Artificially Administered Nutrition

C Check One	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Always offer food and liquid by mouth if feasible and desired.</i> (See Directions on next page for information on nutrition & hydration)	
	<input type="checkbox"/> No artificial nutrition by tube.	<input type="checkbox"/> Defined trial period of artificial nutrition by tube. Goal: _____
	<input type="checkbox"/> Long-term artificial nutrition by tube.	
Additional Orders: _____		

Always offer food and liquid by mouth if feasible and desired.

POLST

Section D – Important Signatures!

- Physician or Advance Practice Registered Nurse (APRN) **and**
- Patient **or** their Legally Authorized Representative (LAR)
- LAR - Agent designated for Health care Power of Attorney ;
 - Parent of a Minor
 - Patient-designated Surrogate
 - Surrogate selected by consensus of interested persons
 - Guardian

D Check One	SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:			
	<input type="checkbox"/> Patient or <input type="checkbox"/> Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below:			
	<input type="checkbox"/> Guardian <input type="checkbox"/> Agent designated in Power of Attorney for Healthcare <input type="checkbox"/> Patient-designated surrogate			
	<input type="checkbox"/> Surrogate selected by consensus of interested persons (Sign section E) <input type="checkbox"/> 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				

Section E: Surrogate Information

- Section E **only** needs to be completed if the patient lacks capacity and has not designated a health care power of attorney
- **Non-Designated Surrogate:** This individual is appointed in accordance with HRS 327E, & has limitations placed upon him or her with respect to decisions about withholding or with-drawing artificial hydration & nutrition.

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

Practical considerations

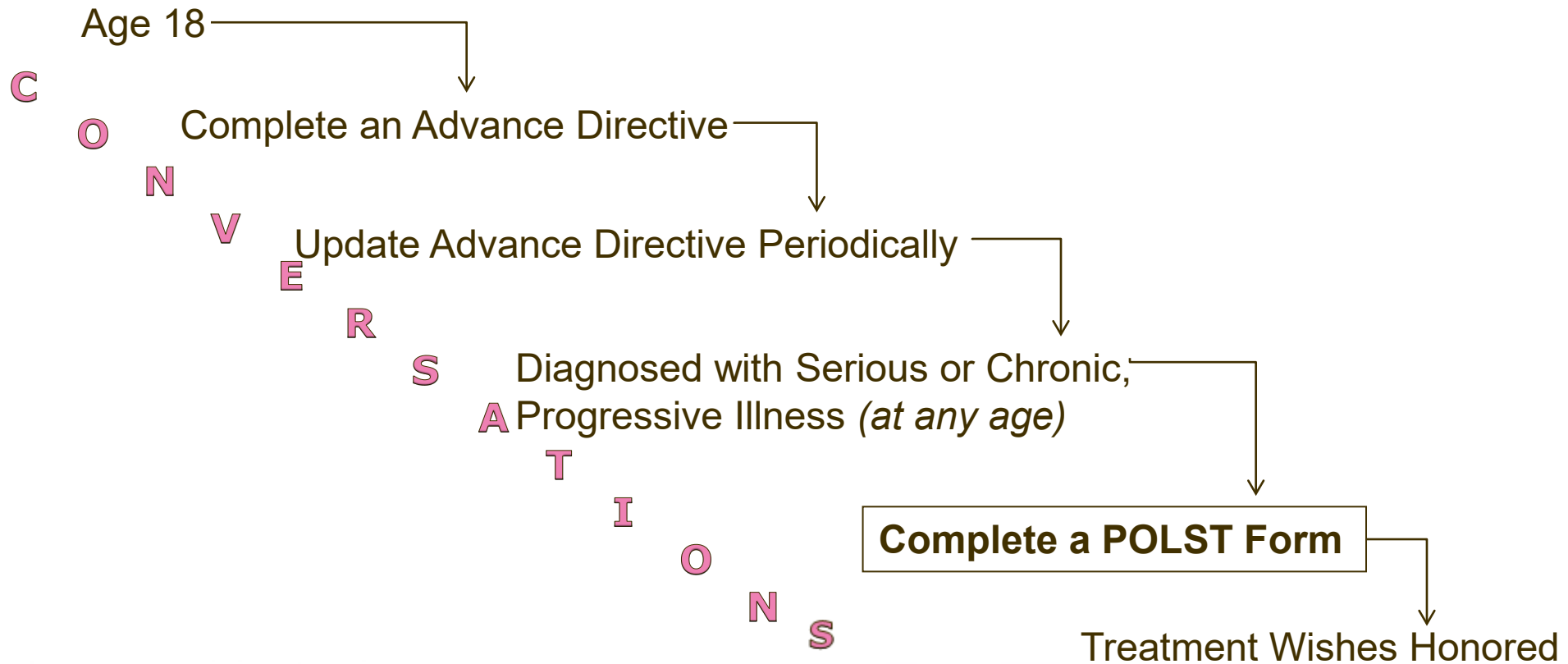
- Recommended to be printed on **lime green** paper (but any color, including black and white is acceptable)
- A copy of the POLST form is legal
- Recommended to be kept in a visible place at home:
 - Refrigerator
 - Bedroom door
 - Bedside table
 - Medicine cabinet
- A copy should be given to EMS personnel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

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?

Advance Care Planning Continuum



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.

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?”

Kokua Mau Resources


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



KOKUA MAU
"Continuous Care"
Hawaii's Hospice and Palliative Care Organization

Executive Office on Aging
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

Kokua Mau
"Continuous Care"
Hawaii's Hospice and Palliative Care Organization

Executive Office on Aging
Department of Health

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	Relationship to individual designated to health care agent
Street Address	City State Zip
Phone	Cell Phone Email

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	Relationship to individual designated to health care agent
Street Address	City State Zip
Phone	Cell Phone Email

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 no provisions for which I have any provided, written or oral, 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 provision of my person needs to be approved for me by a court, I authorize 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 that authority at any time as long as I have mental capacity.

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

A. END OF LIFE DECISIONS
I have an incurable and irreversible condition that will result in my death within a relatively short time. OR
☐ I want to stop or withhold medical treatment that would prolong my life.
☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

B. LIFE SUSTAINING TREATMENT: (You may modify or strike through anything which which you do not agree. Initial and date your modifications.)
I want to stop or withhold medical treatment that would prolong my life.
☐ 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

Questions about CPR

Being asked to make a decision about cardiopulmonary resuscitation (CPR) can be complicated. Few of us have ever seen CPR performed. Our understanding of CPR may come from what we see on TV, where it looks easy and seems to be very successful without any complications. Unfortunately, there is no such thing as CPR that is not completely accurate.

This brochure provides answers to some common questions about what CPR involves and what else 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?
CPR is a longer process than most people realize. It is an attempt to restart the heart when the heart has stopped beating.

WHO IS LEAST LIKELY TO BENEFIT FROM CPR?
Risk factors that are more frequent among older people may contribute to lower chances of CPR survival or 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 even lower.

Individuals in advanced stages of dementia have CPR survival rates three times lower than those without dementia. Several studies that looked at survival of frail 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 of 1-5%.

if the heart continues to respond to these without dementia. Several studies that looked at survival of frail 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 of 1-5%.

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 having honest answers to their questions was most helpful.

HOWEVER... Every situation is different... what may help someone with a short-term correctable eating problem may not be best for long-term use for a person with advanced illness or age.

Kokua Mau - Hawaii's Hospice and Palliative Care Organization

What is a feeding tube?
Artificial nutrition and hydration is a way of giving liquid and nutrients to people who cannot eat or drink by mouth. Usually, for short-term artificial nutrition and hydration, a nasogastric tube (called a "NG" tube) is put through the person's nose and liquid food is put into the stomach. For long-term artificial nutrition and hydration, a tube may be put directly through the skin 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 least helpful?
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 is deprived of food. When a person's body begins to shut down, they may be physically unable to adequately use nutrients that tube feeding would provide, and the chance for bloating and discomfort increases.

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 is deprived of food. When a person's body begins to shut down, they may be physically unable to adequately use nutrients that tube feeding would provide, and the chance for bloating and discomfort increases.

A GUIDE FOR DECISION MAKING

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

First fill out these orders. Then contact the patient's provider. The provider will sign based on the patient's current medical condition and wishes. The provider will sign based on the patient's current medical condition and wishes. The provider will sign based on the patient's current medical condition and wishes.

A. CARDIOPULMONARY RESUSCITATION (CPR): "Person has no pulse and is not breathing"
☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNAR (Allow Natural Death) (Section B. Full treatment requested)

B. 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. Responder if comfort measures cannot be used or comfort limited.
☐ Limited Additional Interventions: Include care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive respiratory support (e.g. continuous or bi-level positive airway pressure). Transfer to hospital if indicated. Avoid invasive care.
☐ Full Treatment: Include care described above. Use medication, advanced airway interventions, mechanical ventilation and defibrillation as indicated. Transfer to hospital if indicated. Avoid invasive care.

C. ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquid by mouth if feasible and desired.
☐ No artificial nutrition by tube. ☐ Softened oral portion of artificial nutrition by tube. ☐ No artificial nutrition by tube. ☐ Long term artificial nutrition by tube.

D. 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 C) ☐ Patient of a Minor

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

Provider Signature (Required) _____ Date _____
Signature of Patient or Legally Authorized Representative
My signature below indicates that to the best of my knowledge and belief these orders are consistent with the patient's medical condition and preferences.

Signature (Required) _____ Date _____
Signature (Required) _____ Date _____
Relationship (circle "self" if patient)

Summary of Medical Condition _____ Other Use Only _____

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

A Provider's Guide to POLST
(Provider Orders for Life-Sustaining Treatment)
Maintained for Hawaii by Kokua 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 more informed decisions. The POLST form documents those 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 can be honored across all settings of care.

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 along the whole continuum of care, from very aggressive, life-sustaining care, to comfort care only, including choice about full 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 significantly more 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 COO-DNR bracket still be honored by EMS?
Yes, the COO-DNR bracket is still a valid method 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.

Why is the POLST form time green?
The POLST form is usually completed on a distinctive single lime-green form, but it is also freely available from the internet (see www.kokumau.org/polst) and is acceptable in black and white. The bright color is to make the form quickly visible to hospitals and emergency medical services personnel. The lime-green color is also easily copied. 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 as well as voluntarily honor the form and include it into their medical records. However, providers with electronic medical records may choose to adapt the essence of the orders into their specific system. Hospital discharge planners are encouraged to support the completion of the POLST form (when clinically appropriate) as a part of their day practice.

Is implementing the orders from the POLST form protected under Hawaii's Law?
Yes, the law states that no provider will be subject to criminal prosecution and civil liability for carrying out the treatment orders in good faith or for performing cardiopulmonary resuscitation if the person performing CPR was unaware of the POLST order or not attempt resuscitation or they believed that the treatment orders (including the DNR order) had been revoked or cancelled.

How do providers get more copies of the POLST form?
The form is available on the Kokua Mau web site: www.kokumau.org/polst in PDF format for easy replication. It is also available that can be on an EMS "1-12" sheet of lime-colored paper. The form must have both sides copied on the front and back of the paper.

Where is the family encouraged to keep the form?
For the patient's home, the POLST form should be kept in a clearly readily accessible by family members. Examples include on 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 Kokua Mau, as of July 2014, www.kokumau.org/polst/updates

What is POLST?
Provider Orders for Life-Sustaining Treatment
A Consumer Guide to POLST
Maintained for Hawaii by Kokua 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)
- Is followed by health care providers, including Emergency Medical Services, such as Paramedics.

You use POLST when you have a serious health condition:
- Sickle cell anemia, heart and other healthcare professionals can help you fill out your own POLST form, but it MUST be signed by your physician or APRN in order to be valid.
- 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 a 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 website 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 feeding tube (see Kokua 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 a POLST form and instructions for your doctor or the doctor's office (see website: www.kokumau.org/polst). The Kokua Mau website is the central source for POLST information for Hawaii. Most hospitals, nursing homes, home health and hospice providers as well as others in the community also have the form for you, and can provide some assistance in understanding it and filling it out. 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?
No, POLST is voluntary and has been available in Hawaii since July 2009. However, without a POLST, Emergency Medical Services (EMS) or other healthcare providers may be required to attempt to restart your heart and breathing should they stop, even if you do not wish 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 lime green POLST form in a location where it can easily be seen. The ideal place is in your medical cabinet where EMS personnel will look for it first. Other visible places could be the back of the 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 medical chart along with other medical orders. A copy of your POLST form on white paper is legal.

Page 1 of 2 - A Consumer Guide to POLST - Provided by Kokua Mau, as of July 2014, www.kokumau.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

Kokua Mau Contact

Jeannette Koijane, Executive Director

jkoijane@kokuamau.org

808-585-9977

Hope Young, ACP Coordinator

hope@kokuamau.org

808-221-2970

www.theconversationproject.org

ACP Strategies

Talking about what matters

April 12, 2022



Definitions



“The whole process of discussion of end-of-life care, clarification of related values and goals, and embodiment of preferences through written documents and medical orders. This process can start at any time and be revisited periodically, but it becomes more focused as health status changes.”

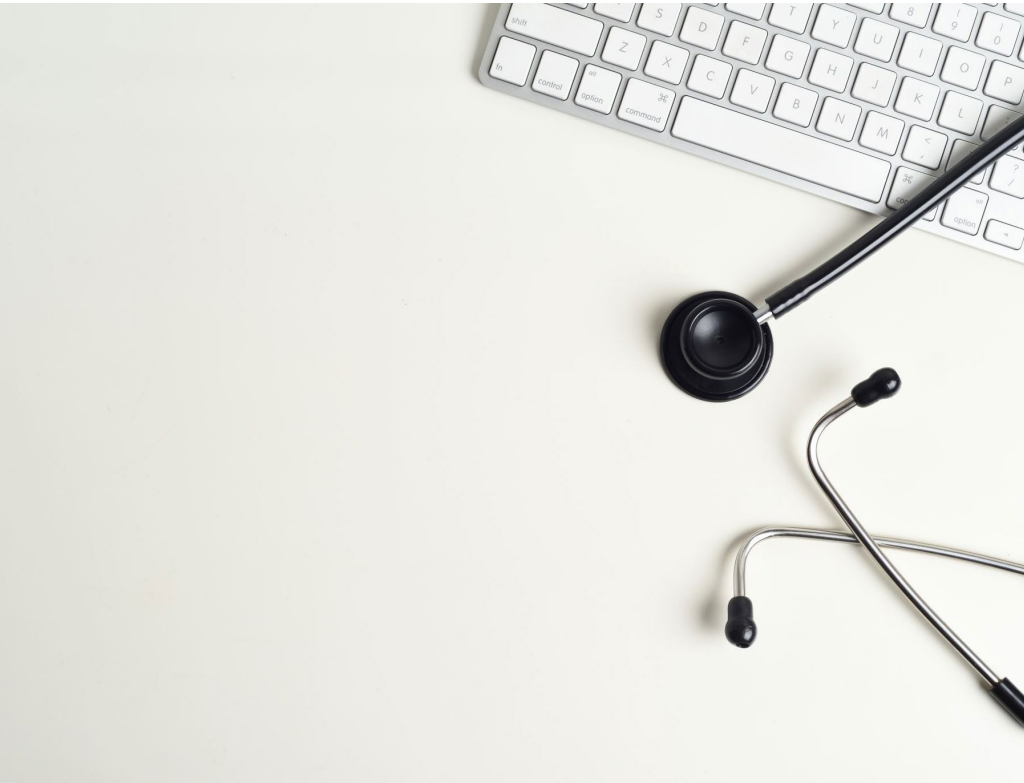
Dying in America: Improving Quality and Honoring individual Preferences Near the End of Life, National Academy of Sciences, 2014

What the Regs Say



“A resident who is at the end of life or in terminal stages of an illness or who has multiple organ system failures may have written directions for his or her treatment goals (or a decision has been made by the resident’s surrogate or representative, in accordance with State law). Although a facility’s care must reflect a resident’s wishes as expressed in the Directive, in accordance with State law, the presence of an Advance Directive does not absolve the facility from giving supportive and other pertinent care that is not prohibited by the Advance Directive*”

Facility Requirements



- Provide written information about the right to formulate an advance directive
- Document in record
- Can't provision care or discriminate due to an advance directive
- Educate staff on policies and procedures

Important Caveat-DNR



The presence of a "Do Not Resuscitate" (DNR) order is not sufficient to indicate the resident is declining other appropriate treatment and services. It only indicates that the resident should not be resuscitated if respirations and/or cardiac function cease.

Avoid Citations



- Ensure the care plan is resident-centered, individualized and consistent with their wishes
- Implement appropriate interventions or document why you cannot/should not implement
- Provide care based on the resident's needs

QI Efforts



- Periodically assess the number of residents who have advance directives in place
- Educate on strategies for having compassionate end of life conversations
- Consider adjusting efforts to boost completion: host an event, develop an awareness or education campaign for residents and families
- Ensure you have the appropriate staff members on your palliative team

Resources/References

[SOM - Appendix PP \(cms.gov\)](#)

[How to Talk to Your Patients about End-of-Life Care \(ihi.org\)](#)

[Coffee and Conversation: How to Encourage Advance Care Planning \(ihi.org\)](#)

[The Conversation Project - Have You Had The Conversation?](#)

This material was prepared by Mountain-Pacific Quality Health, a Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO), under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW-MPQHF-HI-NH-02/22-03

OPEN FOR DISCUSSION



THANKS FOR CARING!

LOOK FOR 3 THINGS:

#1

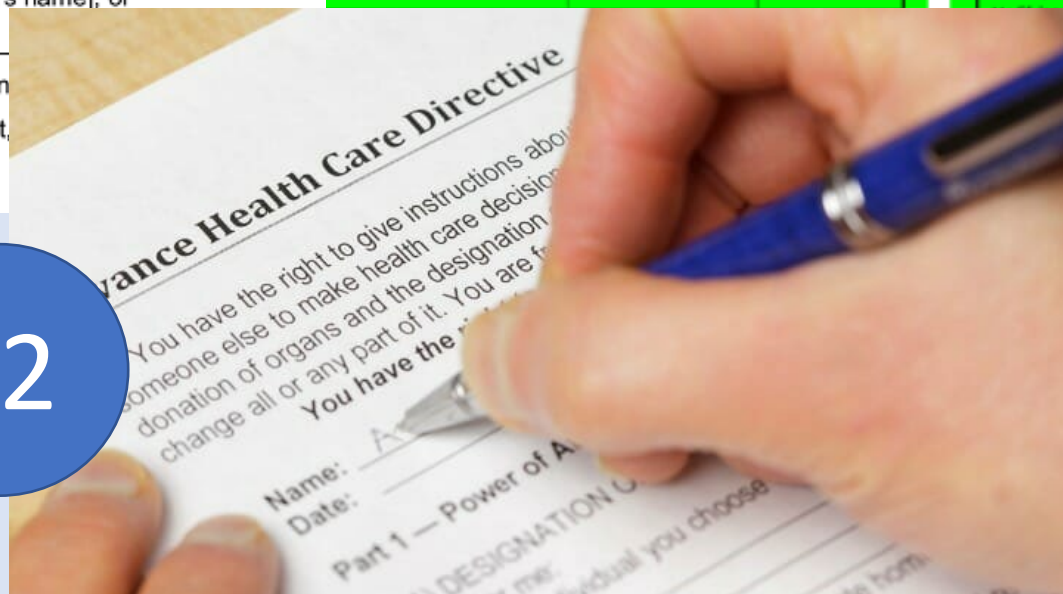
GENERAL POWER OF ATTORNEY

OF

Jane Doe

I, _____, the Principal, of _____ [street address], City of _____, State of _____, hereby designate _____, [attorney-in-fact's name], of _____ [street address], City of _____, State of _____, my attorney-in-fact (herein to act as set forth below, in my name, in my stead and for my benefit, all powers of attorney I may have executed in the past.

#2



#3

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 patient's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone should 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"**
[] 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"**
[] 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) if indicated. Avoid intensive care.
Transfer to hospital if indicated. Avoid intensive care.

Artificially Administered Nutrition: Always offer food and liquid by mouth if feasible and desired
[] Artificially Administered Nutrition: Always offer food and liquid by mouth if feasible and desired
[] Artificially Administered Nutrition: Always offer food and liquid by mouth if feasible and desired

VALUES AND SUMMARY OF MEDICAL CONDITION - Discussed with: _____
[] Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below:
[] 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

Provider (Physician/APRN licensed in the state of Hawaii): _____
Signature: _____ Date: _____
Title: _____

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

Patient Name (last, first, middle): _____

Patient's Preferred Emergency Contact or Legally Authorized Representative: _____
Name: _____ Address: _____
Health Care Professional Preparing Form: _____ Preparer Title: _____ Date: _____

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 as a legally authorized representative for the patient named on this form. The patient has been determined by _____ 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 each person of the patient's best interests 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's Revised Statutes §327B-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 or Advanced Practice Registered Nurse (APRN) 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.

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 "Do Not Attempt Resuscitation."
- Section B:**
 - When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," 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 Measures Only."
 - A person who desires IV fluids should indicate "Limited Interventions" 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 §327B-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.

Voiding POLST

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

Kāhala Maui - Hawaii's Hospice and Palliative Care Organization
The lead agency for implementation of POLST in Hawaii. Visit www.kahalamau.org/polst to download a copy and more POLST information. This form has been adopted by the Department of Health July 2024.
Kāhala Maui • PO Box 62235 • Honolulu HI 96828 • info@kahalamau.org • www.kahalamau.org

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Please Share with our Team:

You will receive a link to fill out an online survey form to share how many of your residents have these 3 documents.

Please try have someone screen all your residents before our next session.

Please try to complete this, it helps us demonstrate that you are doing a good job helping residents achieve their wishes!

DOCUMENT	HOW MANY HAVE?	TOTAL# RESIDENTS
Power of Attorney		
Advanced Care Planning (e.g. DPOA HC)		
POLST form		

NEED HELP?

- MONDAY, 4/18/22
 - 2pm

Mibrao@hawaii.edu

