- ✓ **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/

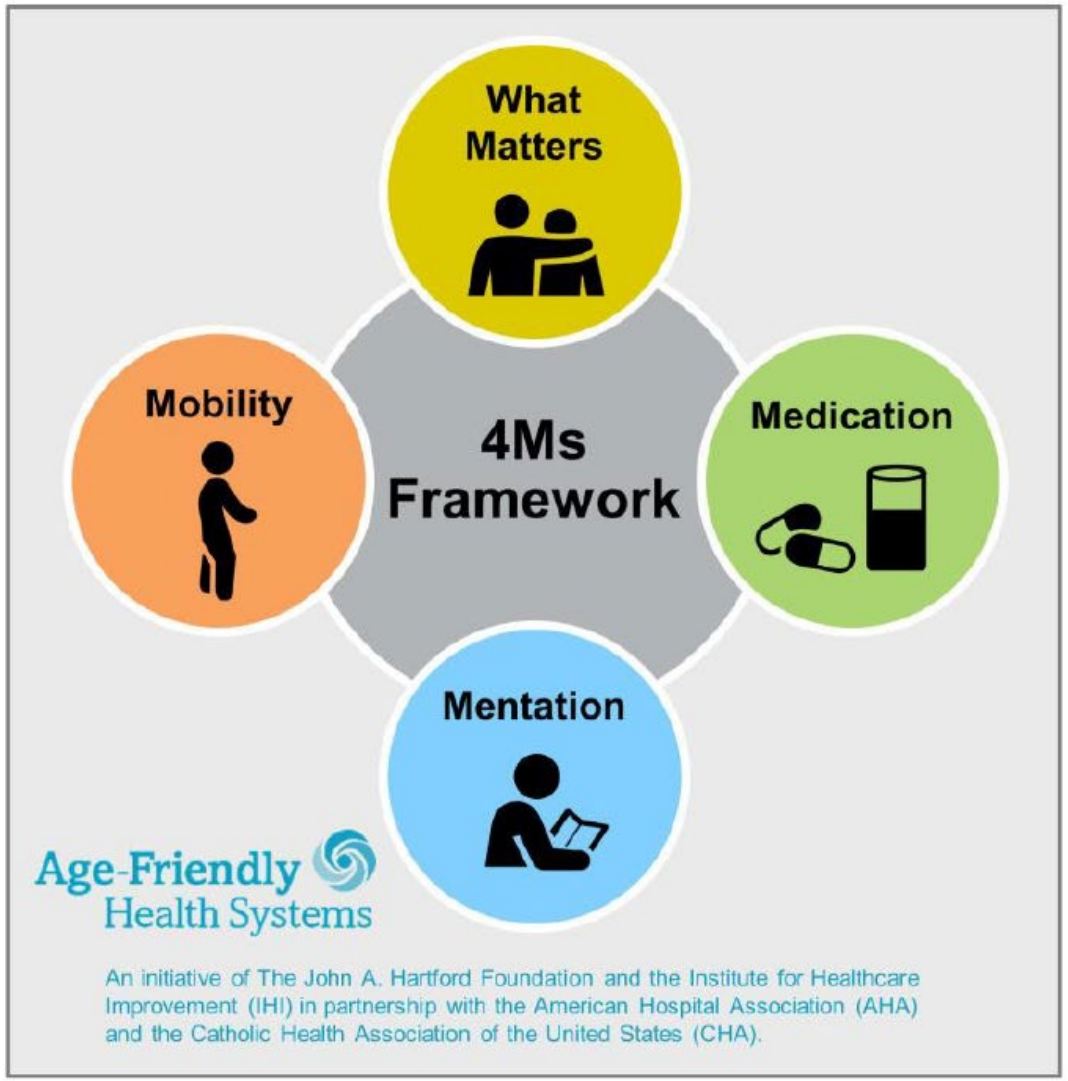
** Some systems do not allow access to google forms. Fillable PDFs can be found on our website. Please send to Jon at Nakasone@hawaii.edu

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



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.

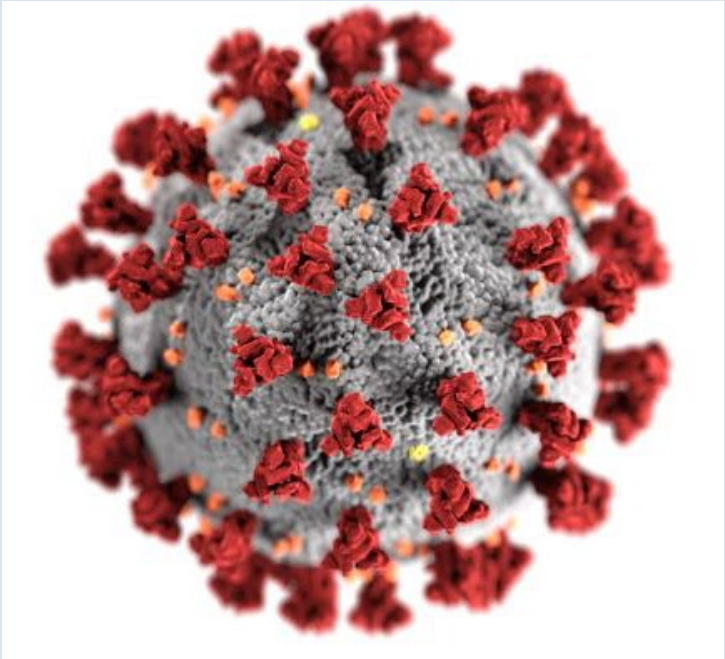
Wellness

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 they way health care is provided

"I'm not afraid of death; I just don't want to be there when it happens."

~Woody Allen

the conversation project

Kōkua Mau
Continuous Care
A Movement to Improve Care

If the unexpected happened,

Who would speak for you?

Would they know what you would want?

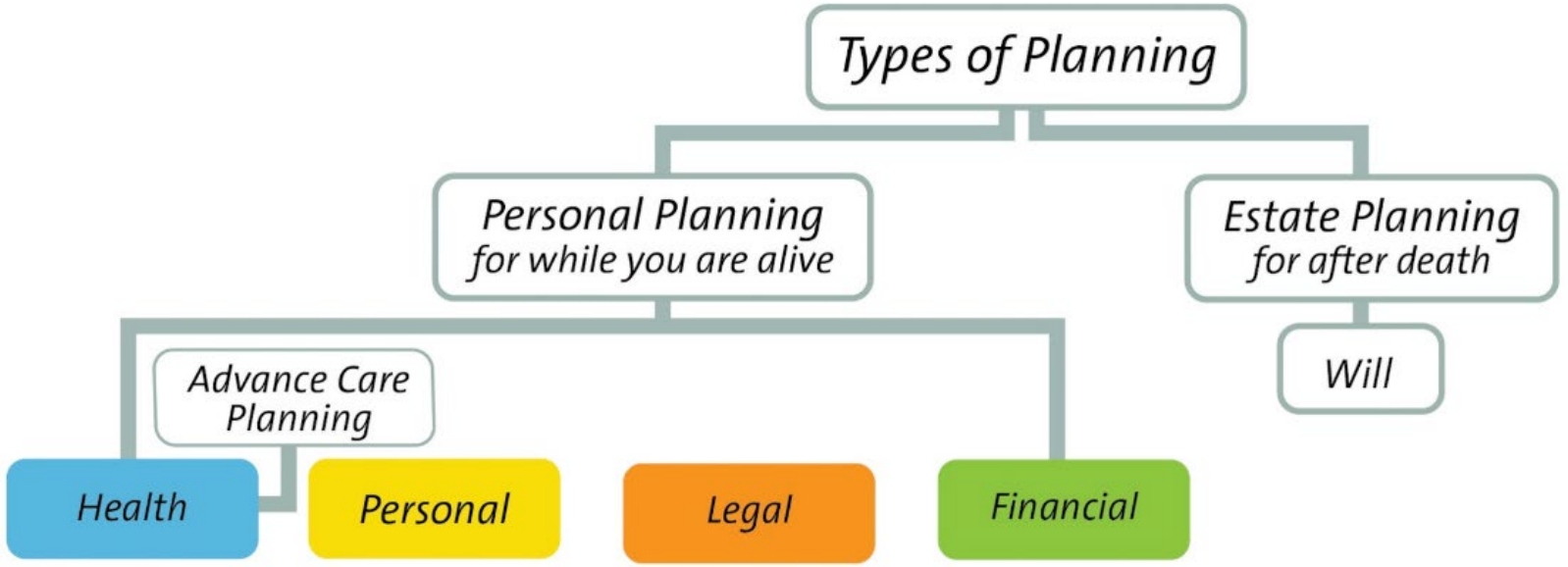
Or possibly what you would not want?

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

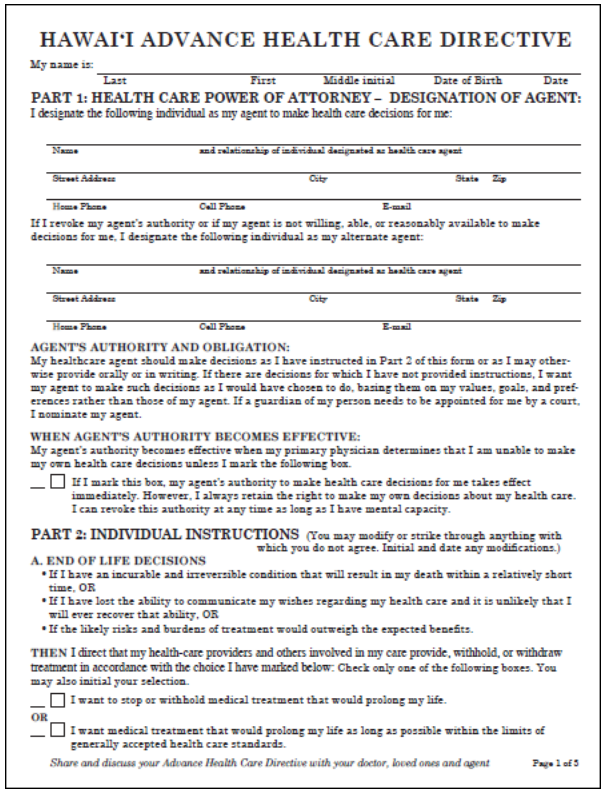
- Without an AD, precious time could be spent trying to designate a Health Care Agent from “interested parties”, there is no next-of-kin hierarchy in the state of Hawaii. If the “interested parties” cannot come to an agreement, it could become a guardianship case, which could take 6 months to resolve

Cover all your bases!



Source: Nidus Personal Planning Resource Centre and Registry

Advance Health Care Directive



HAWAI'I ADVANCE HEALTH CARE DIRECTIVE

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

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

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

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

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

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

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

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

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

A. END OF LIFE DECISIONS

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

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

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

OR

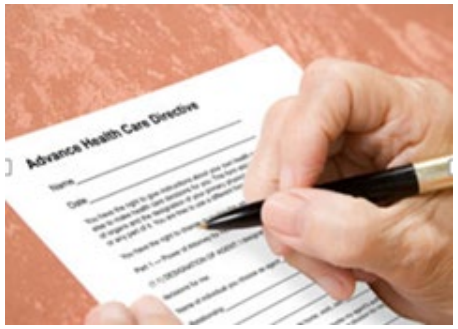
__ ☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent Page 1 of 5

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

Advance Health Care Directive (AHCD)

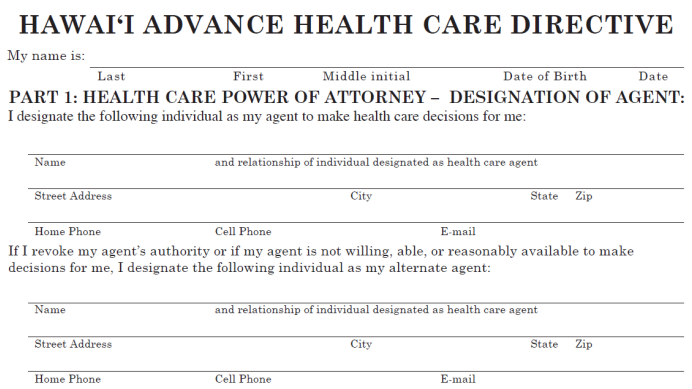
- Legal document completed only when you are of **sound mind**



- 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



HAWAIʻI ADVANCE HEALTH CARE DIRECTIVE

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

PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

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

Name and relationship of individual designated as health care agent

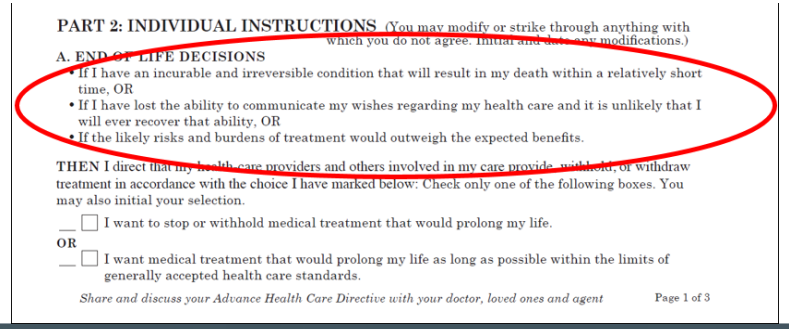
Street Address City State Zip

Home Phone Cell Phone E-mail

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

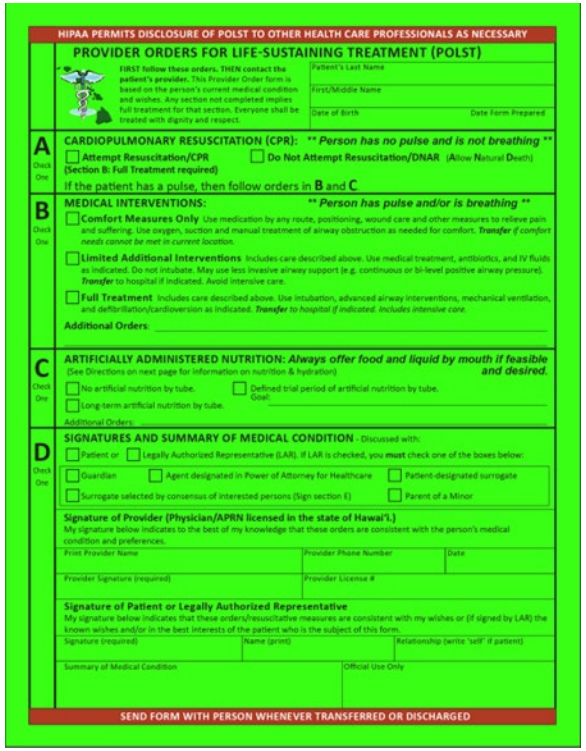
Two Witnesses

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?

- **P**rovider
- **O**rders for
- **L**ife
- **S**ustaining
- **T**reatment



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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

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

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

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

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

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

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

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

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

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

Additional Orders:

C Check One — ARTIFICIALLY ADMINISTERED NUTRITION: *Always offer food and liquid by mouth if feasible and desired.*

(See Directions on next page for information on nutrition & hydration)

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

☐ Long-term artificial nutrition by tube.

Additional Orders:

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

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

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate

☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Provider Name | Provider Phone Number | Date

Provider Signature (required) | Provider License #

Signature of Patient or Legally Authorized Representative

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

Signature (required) | Name (print) | Relationship (write "self" if patient)

Summary of Medical Condition | Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Who Would Benefit from Having a POLST Form?

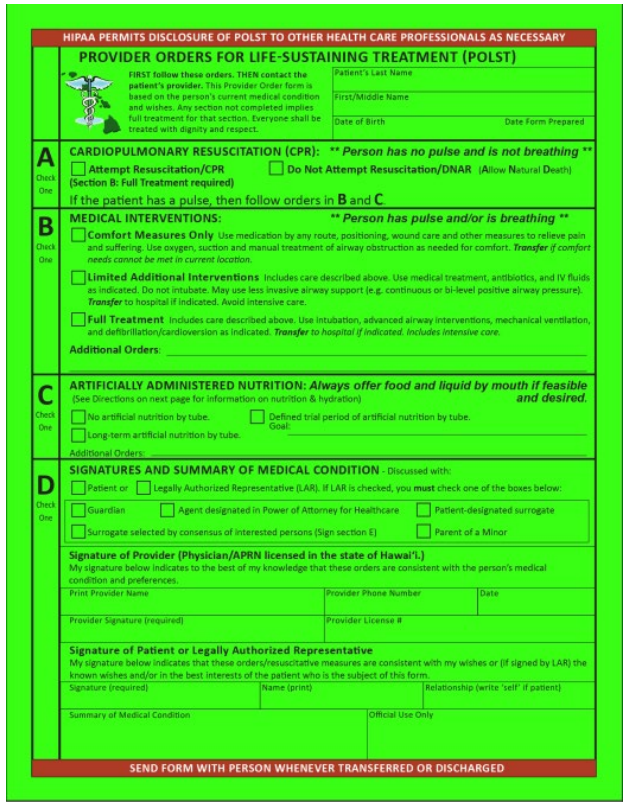
- Chronic, progressive illness
- Serious health condition
- Medically frail
- A person for whom you would issue an in-patient DNR order
- “Would you be surprised if this patient died within the next year?”

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)

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

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

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

☐ Attempt Resuscitation/CPR ☐ 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* **

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

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

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

Additional Orders: _____

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** ***Always offer food and liquid by mouth if feasible and desired.***

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. Goal: _____

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

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

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

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate

☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Provider Name | Provider Phone Number | Date

Provider Signature (required) | Provider License #

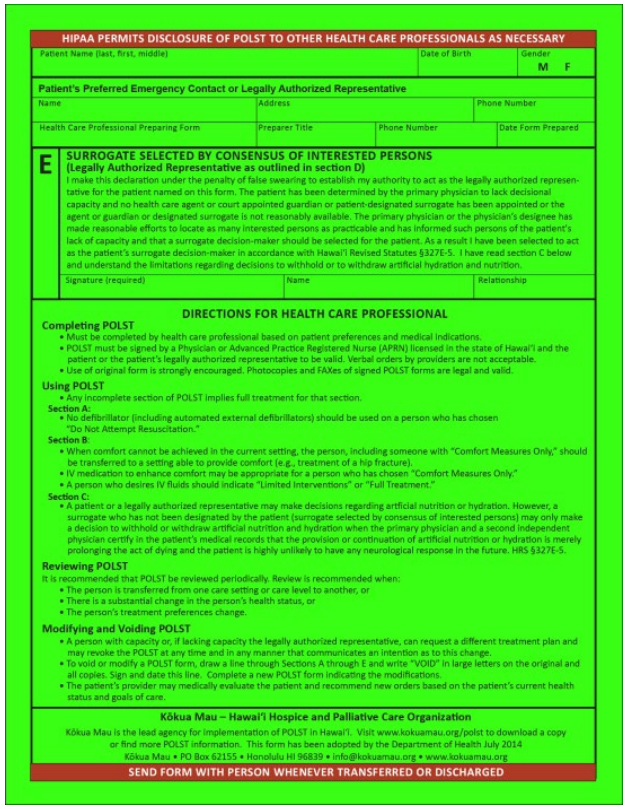
Signature of Patient or Legally Authorized Representative

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

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

Summary of Medical Condition | Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED



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 **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

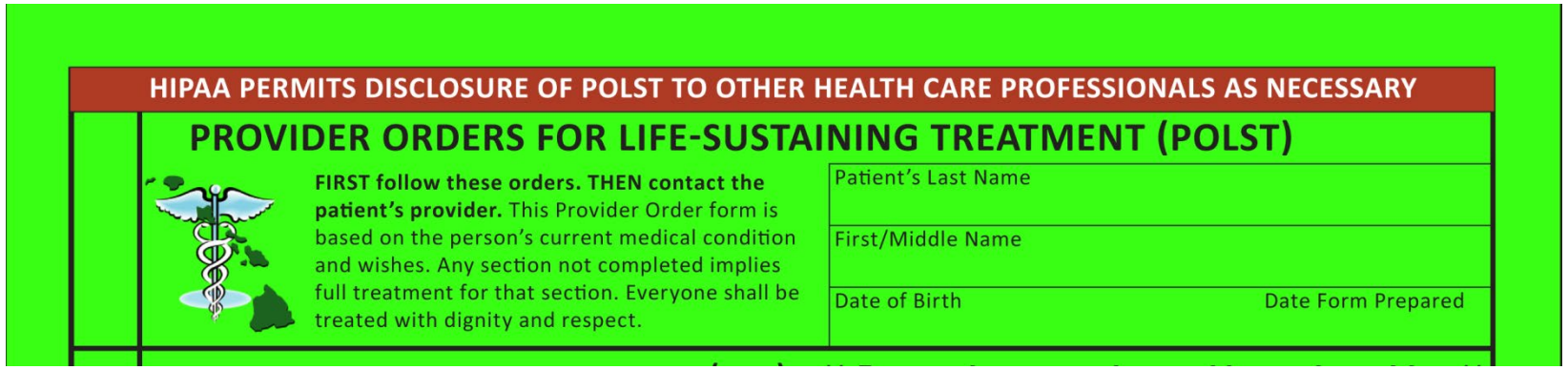
Kōkua Mau is the lead agency for implementation of POLST in Hawai'i. Visit www.kokuamau.org/polst to download a copy or find more POLST information. This form has been adopted by the Department of Health July 2014

Kōkua Mau • PO Box 62155 • Honolulu HI 96839 • info@kokuamau.org • www.kokuamau.org

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Kōkua Mau Continuous Care
A Movement to Improve Care

HI POLST Form – Information



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

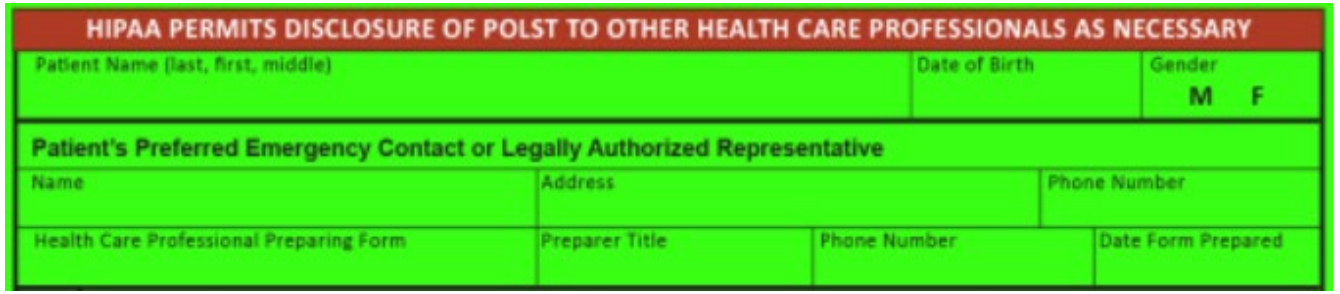
PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

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

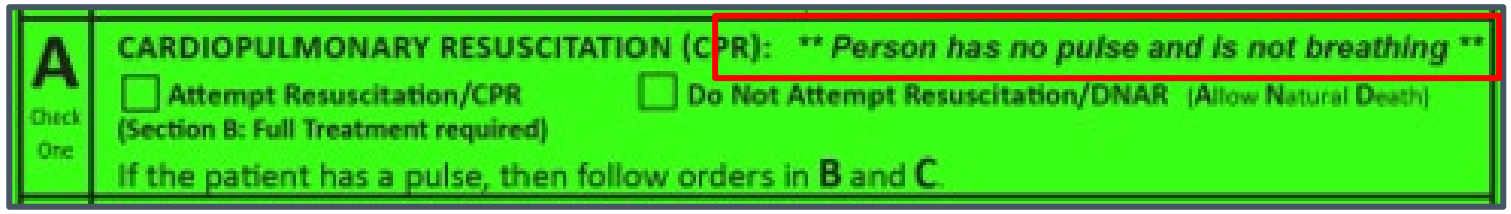
Patient Name (last, first, middle)	Date of Birth	Gender M F

Patient's Preferred Emergency Contact or Legally Authorized Representative

Name	Address	Phone Number

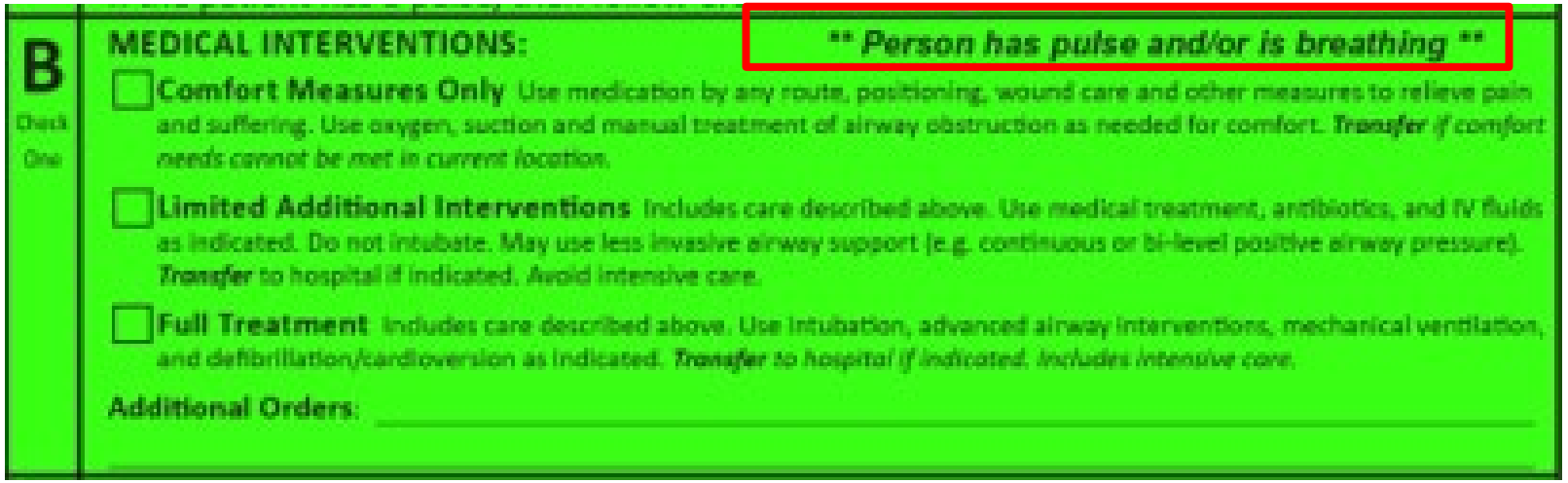
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Form Prepared

Section A:
Cardiopulmonary Resuscitation (CPR)



Person has no pulse and is not breathing*

Section B:
Medical Interventions



B

Check One

MEDICAL INTERVENTIONS:

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

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

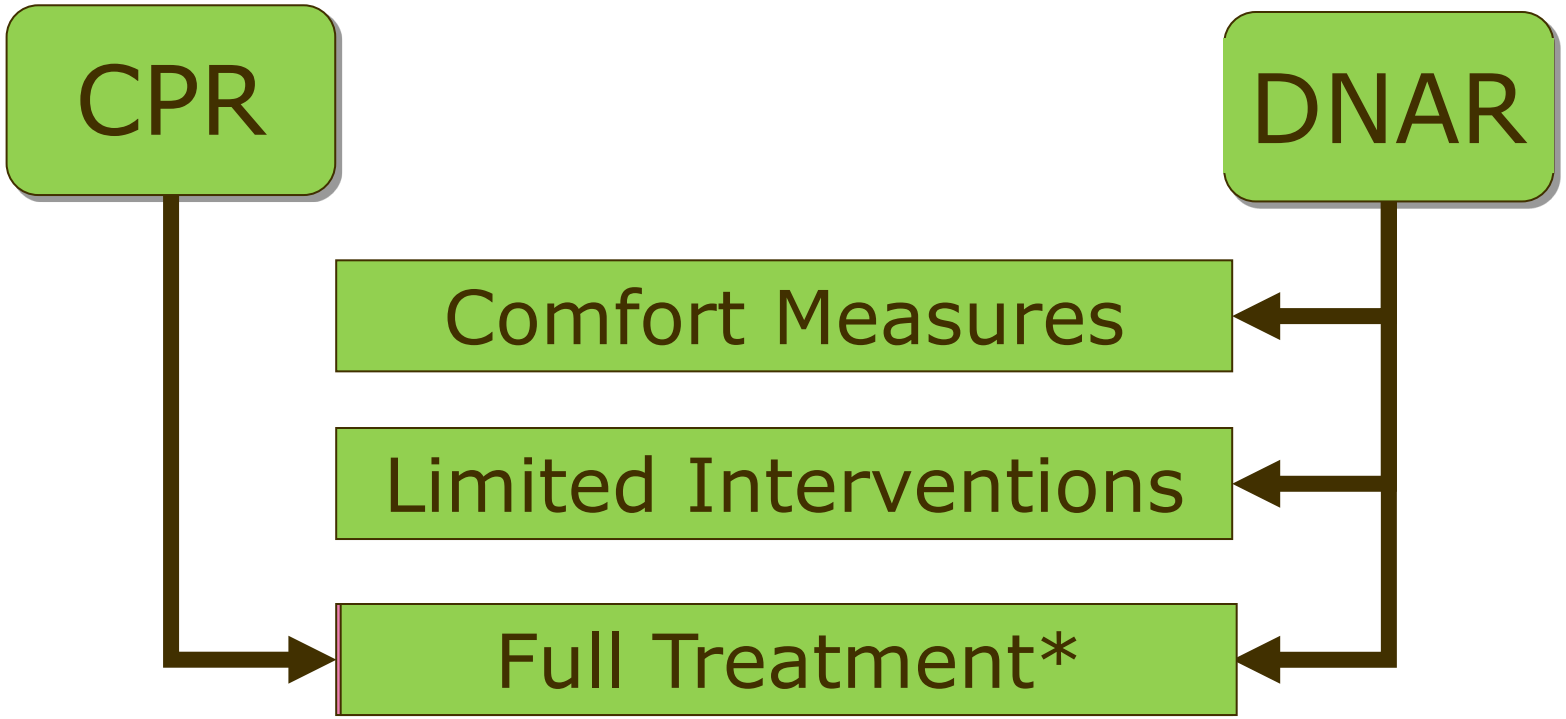
☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). ***Transfer*** to hospital if indicated. *Avoid intensive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

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

Additional Orders: _____

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

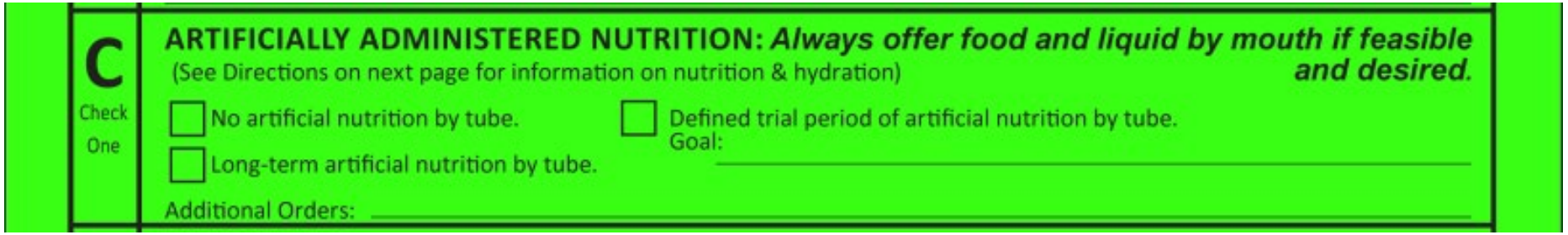
Diagram of POLST Medical Interventions



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

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.
Goal: _____

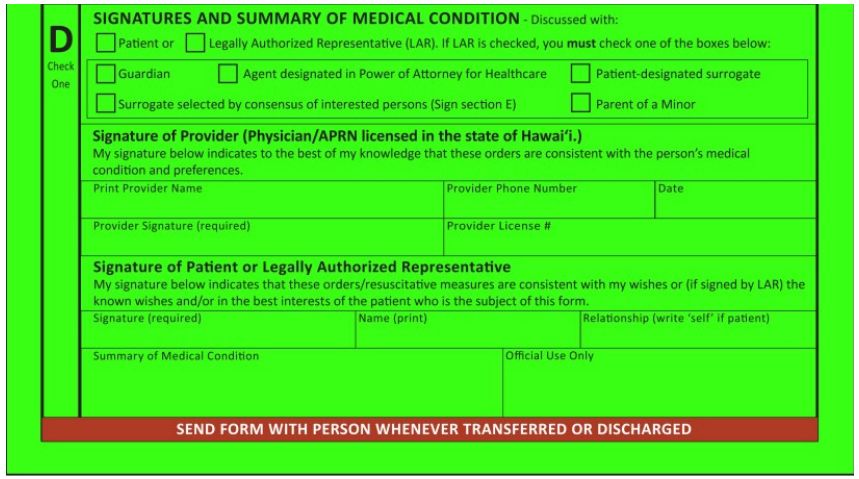
☐ Long-term artificial nutrition by tube.

Additional Orders: _____

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:

☐ 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

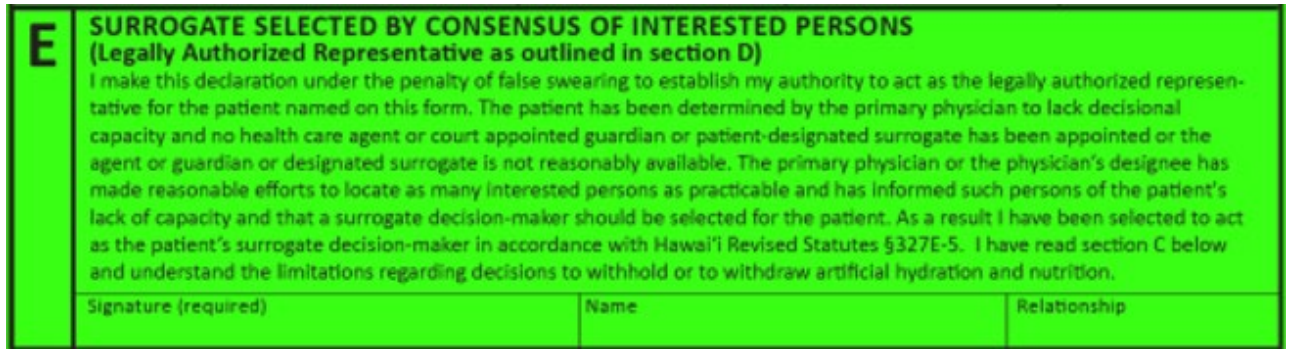
My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

Signature (required)	Name (print)	Relationship (write 'self' if patient)
Summary of Medical Condition	Official Use Only	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Section E: Surrogate Information

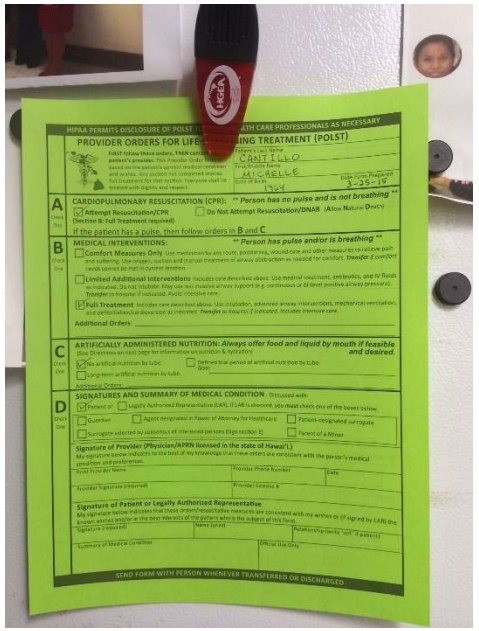
- Section E **only** needs to completed if the patient lacks capacity and has not designated a health care power of attorney
- ***Non-Designated Surrogate:*** This individual is appointed in accordance with HRS 327E, & has limitations placed upon him or her with respect to decisions about withholding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

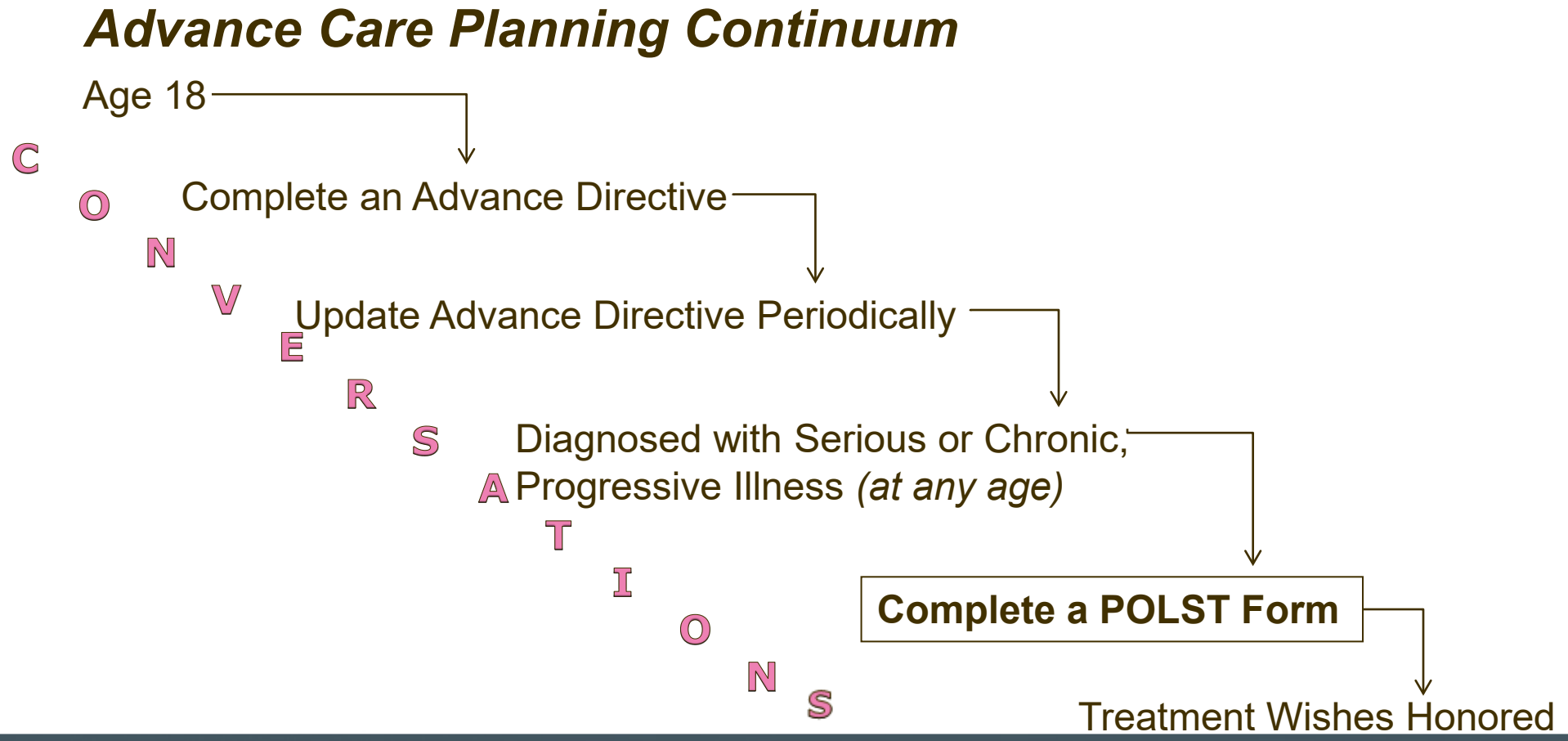
- Recommended to be printed on **lime green** paper (but any color, including black and white is acceptable)
- A copy of the POLST form is legal
- Recommended to be kept in a visible place at home:
  - Refrigerator
  - Bedroom door
  - Bedside table
  - Medicine cabinet
- A copy should be given to EMS 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?



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

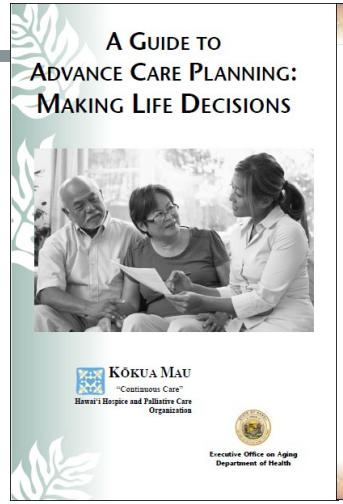
- Change the question:

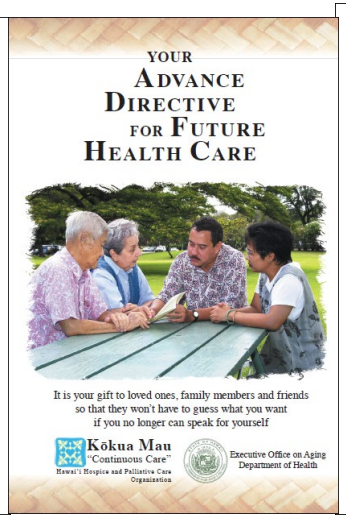
  “What’s the matter with me?”

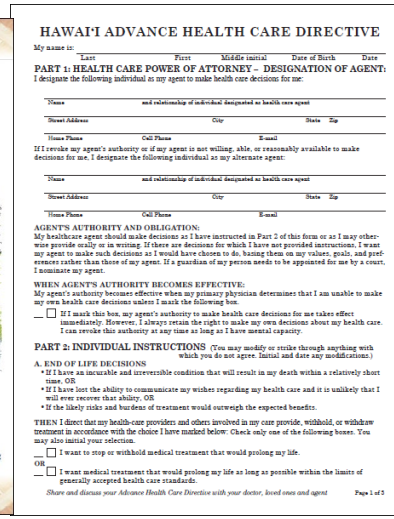
  to

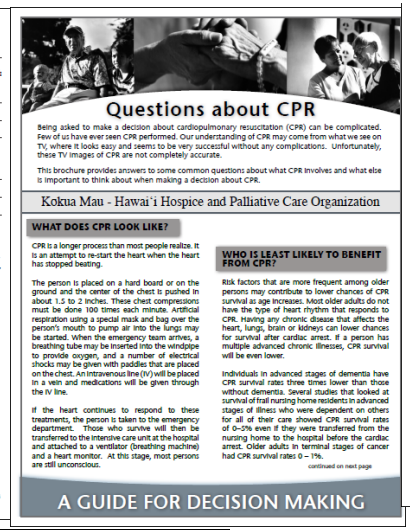
  “What matters TO me?

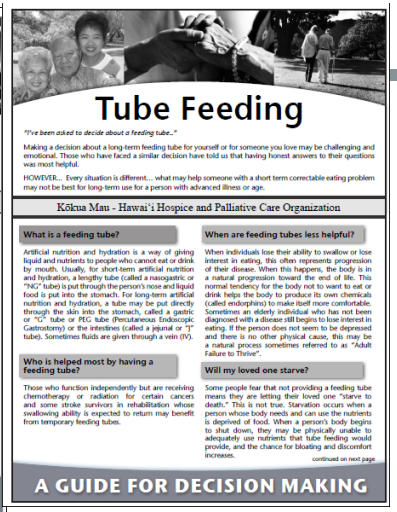
Kokua Mau Resources

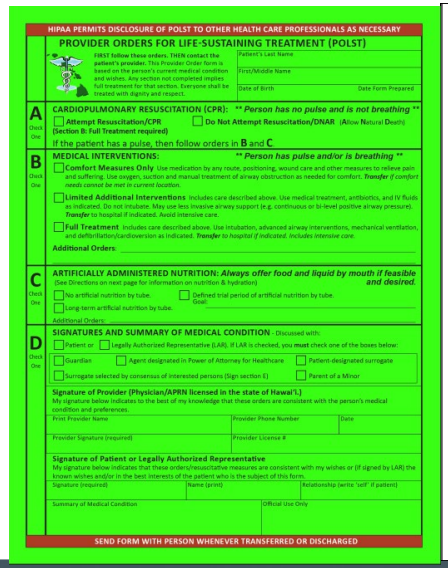


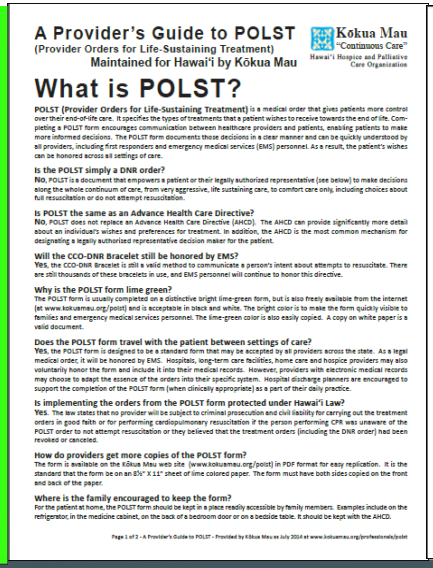


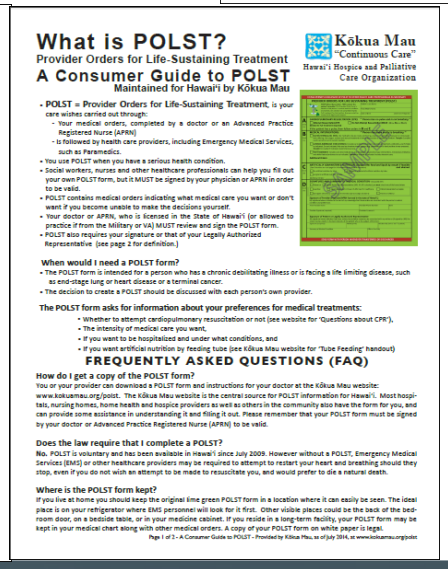












[Chinese simplified](#) Hawaii **Advance** Health Care **Directive**
[Chinese traditional](#) Hawaii **Advance** Health Care **Directive**
[Ilocano](#) Hawaii **Advance** Health Care **Directive**
[Japanese](#) Hawaii Advance Health Care Directive
[Korean](#) Hawaii **Advance** Health Care **Directive**
[Marshallese](#) Hawaii Advance Health Care Directive
[Spanish](#) Hawaii **Advance** Health Care **Directive**
[Tagalog](#) Hawaii **Advance** Health Care **Directive**
[Tongan](#) Hawaii Advance Health Care Directive
[Vietnamese](#) Hawaii **Advance** Health Care **Directive**

Since June 2016 the ***Hawaii POLST Form*** is available in [10 languages](#).

- [Chinese simplified](#)POLST Form for Hawai'i
- [Chinese traditional](#) POLST Form for Hawai'i
- [Ilocano](#) POLST Form for Hawai'i
- [Japanese](#) POLST Form for Hawaii
- [Korean](#) POLST Form for Hawaii
- [Marshallese](#) POLST Form for Hawaii
- [Spanish](#) POLST Form for Hawai'i
- [Tagalog](#) POLST Form for Hawai'i
- [Tongan](#) POLST Form for Hawaii
- [Vietnamese](#) POLST Form for Hawai'i

http://www.kokuamau.org/

Kōkua Mau
Continuous Care
A Movement to Improve Care

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

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mountain-Pacific Quality Health

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

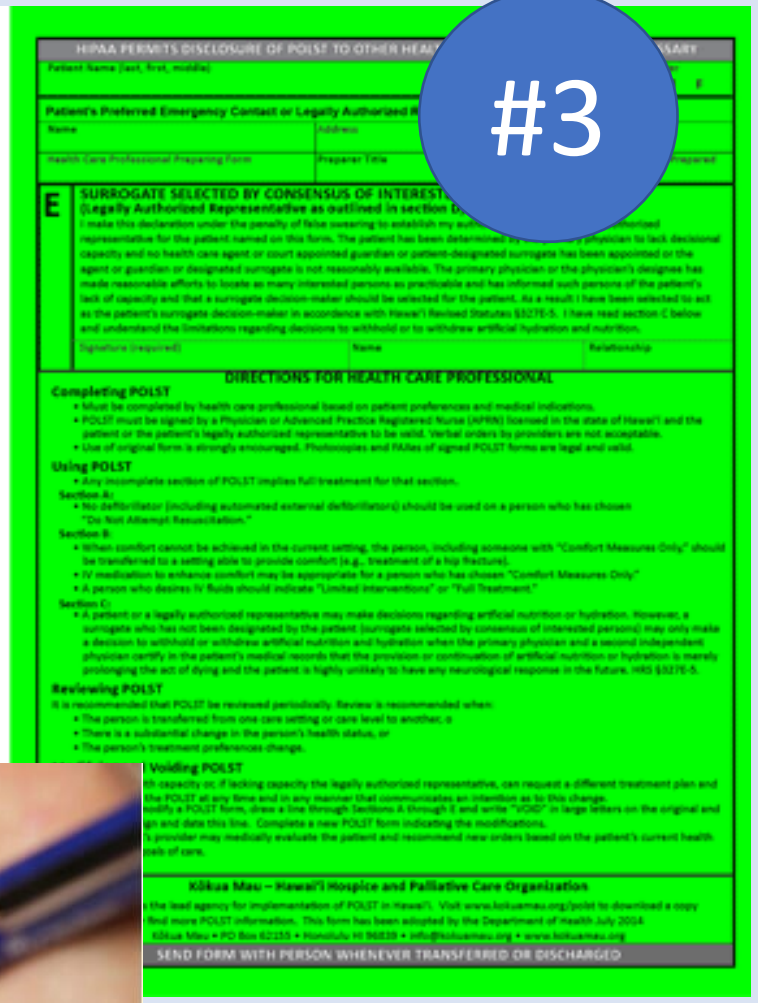
OF

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



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