POLST ILLINOIS

Practitioner Orders for Life-Sustaining Treatment

Ambulatory Setting

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DISCLAIMER

- Note that this presentation provides clinical guidance for the POLST Paradigm and should NOT be construed as medical nor legal advice.

- For answers to legal questions, check with your own legal counsel.

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Objectives

By the end of this session, participants will be able to:

- Understand the **POLST Model** and when it is an appropriate part of advanced care planning
- Describe the relationship between Advance Directives and POLST forms, and when each is appropriate for completion
- Describe the elements of a quality POLST conversation
- Understand the sections of the POLST form
- Recognize the importance of care providers being properly educated regarding POLST Model policy and practice

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Practitioner Orders for Life-Sustaining Treatment

POLST Program Overview

What is POLST?

- In Illinois - POLST stands for **Practitioner*** Orders for Life Sustaining Treatment
- It is NOT just a form, **it is a process**
  - Approach to end-of-life planning based on thoughtful conversations with the person, a friend or family if desired, and healthcare professionals
  - Incorporates values, beliefs and priorities as these relate to prognosis, likely disease course & treatment choices

* Physician, Advanced Practice Registered Nurse, Physician Assistant, Resident in 2nd year or higher of residency program

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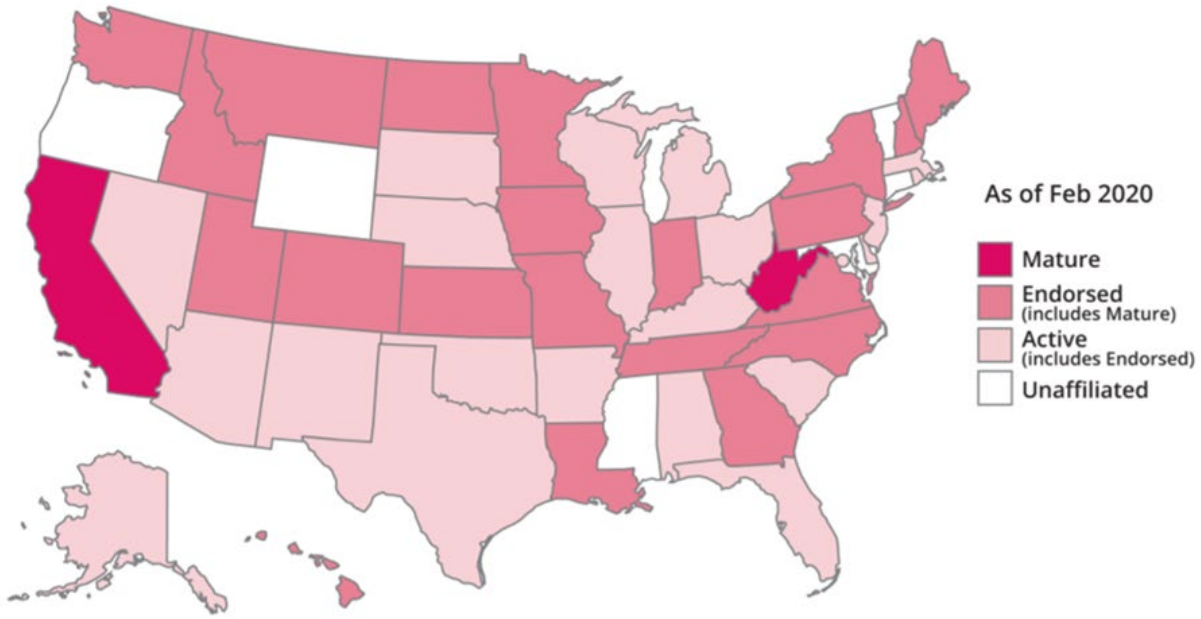
Where did POLST come from?

National POLST
www.polst.org

National POLST Program Designations
As of February 2020



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Why would a person need a POLST form?

- Helps ensure appropriate care and treatment if a person experiences an acute deterioration of their health
- Helps share goals-of-care preferences and instructions amongst family caregivers or when transferring sites of care (e.g., nursing home, paramedics, hospital, home)
- Allows loved ones to contact 911 in a critical medical emergency without fear of patient receiving unwanted treatment if death is imminent

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Why does the POLST Form exist?

First responders need clear guidance for how to respond to a medical emergency in the field

- Recognized IDPH standardized form for the entire state of Illinois
- Concrete **medical orders** that must be followed by healthcare providers and first responders, so that treatment is in keeping with the person's wishes
- Evolved from the original IDPH DNR form (prior versions of forms are valid)

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Who should have a POLST Form?

The POLST decision-making process and resulting medical orders are intended for people of any age who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.

This includes but is not limited to people with:

- Severe Heart Disease
- Metastatic Cancer or Malignant Brain Tumor
- Advanced Lung, Renal or Liver Disease
- Advanced Frailty
- Advanced Neurodegenerative Disease
  (e.g., Dementia, Parkinson's Disease, ALS)

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What else to know about a POLST?

- Most people over age 65 are too healthy to have POLST orders.
- POLST **is not intended** for people with chronic, stable disability, who must not be mistaken for being at the end of life.
- The POLST form speaks for patients **ONLY** when they can't speak for themselves.
- The patient can void or change their POLST form at anytime as their disease and health changes.
- A patient without POLST orders receives FULL TREATMENT as the default, and this **may** be a reason not to complete the form.
- **Accompanies patient from care setting to care setting**

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How is a POLST Form different from a Power of Attorney for Health Care?

	POWER of ATTORNEY for HEALTH CARE	POLST Form
Who needs	All Decisional Adults	Serious Life-limiting Medical Condition
Who completes	Individual	Health Care Practitioner
Appoints a substitute decision maker	Yes	No
Real-time instructions for first responders	**No**	**Yes**

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What are the benefits of POLST?

Promotes Person-Centered Care

- Allows the person, loved ones and providers to discuss and document the person's values and preferences for treatment in a medical emergency
- Protects individuals who live in the community from treatment that is inconsistent with their preferences
- Reduces medical errors by improving guidance during life-threatening emergencies

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IDPH Uniform POLST:
I. The Conversation

Introducing the POLST Conversation

WHO:

- Physician
- APRN
- PA
- RN
- Social Worker
- Chaplain

❖ Qualified healthcare practitioner reviews orders & signs form

WHAT TO DO:

✓ Use simple language

✓ Start with a **DISCUSSION**, then end with the POLST form itself

✓ Explain under what circumstances the form might be useful

✓ Ensure that the individual has necessary information to make each decision

✓ Inform that POLST form is optional and can be changed at any time

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POLST Conversation – BEFORE the Form

- Review relevant medical facts; uncovering gaps in person's understanding of prognosis
- **Explore** experiences; identifying fears and concerns
  - Awareness of potential complications resulting from illness
  - Awareness of potential emergency treatments of these complications (e.g., CPR, intubation, hospitalization in ICU)
- Ask patient to reflect on goals/values and how they influence preferences
- And then, put the preferences in writing to translate them into actionable medical order

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Demonstrating That You Care

- Always approach with compassion
- Ask for permission to proceed with difficult discussions
- Encourage understanding between patients and family members
  - Hearing the information for the first time is hard.
  - It's normal to need time to think things through.
  - Use multiple conversations as needed.

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IDPH Uniform POLST:
II. The Form

The IDPH Uniform POLST Form

HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

State of Illinois
Illinois Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIP code)		

A Check One

CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

❑ **Attempt Resuscitation/CPR** ❑ **Do Not Attempt Resuscitation/DNR**

(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

When not in cardiopulmonary arrest, follow orders B and C.

B Check One

MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

❑ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

❑ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

❑ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

C Check One

MEDICALLY ADMINISTERED NUTRITION (If medically indicated) Offer food by mouth, if feasible and as desired.

❑ Long-term medically administered nutrition, including feeding tubes. **Additional Instructions (e.g., length of trial period)**

❑ Trial period of medically administered nutrition, including feeding tubes. _____

❑ No medically administered means of nutrition, including feeding tubes. _____

D

DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Agent under health care power of attorney

❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature *(required)*	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature *(required)*	Name (print)	Date

E

Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

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

Print Authorized Practitioner Name *(required)*	Phone ( ) -
Authorized Practitioner Signature *(required)*	Date *(required)*

Page 1

Form Revision Date - May 2017 (Prior form versions are also valid.)

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2017

HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

"THIS SIDE FOR INFORMATIONAL PURPOSES ONLY"

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- **The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g. ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

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Page 2

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3 Primary Medical Order Sections

A. If NO pulse and NO breathing: CPR wishes

- Attempt resuscitation
- Do Not Attempt resuscitation (DNR)

B. If pulse and/or breathing are present: Care wishes

- Full Treatment
- Selective Treatment
- Comfort-Focused Treatment

C. Medically Administered Nutrition

- Acceptable
- Trial Period
- None

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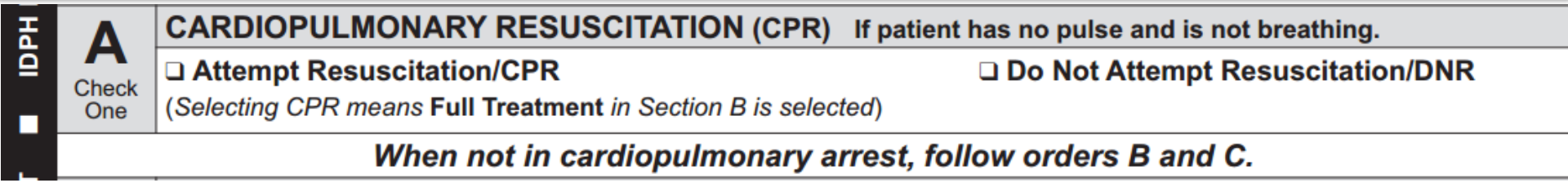
Section “A”: Cardio-Pulmonary Resuscitation



IDPH

A Check One

CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

❑ **Attempt Resuscitation/CPR** ❑ **Do Not Attempt Resuscitation/DNR**

(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

When not in cardiopulmonary arrest, follow orders B and C.

Section A documents what a person wishes to occur if they are found with no pulse and not breathing.

The presence of a POLST form DOES NOT mean DNR. Patients can use a POLST Form to indicate “Attempt Resuscitation” as well as “Do Not Attempt Resuscitation”.

☑ If “Attempt Resuscitation/CPR” box checked: Start CPR and full cardiac arrest care per local protocol.

☒ If “DNR” box checked: **Do NOT** begin CPR.

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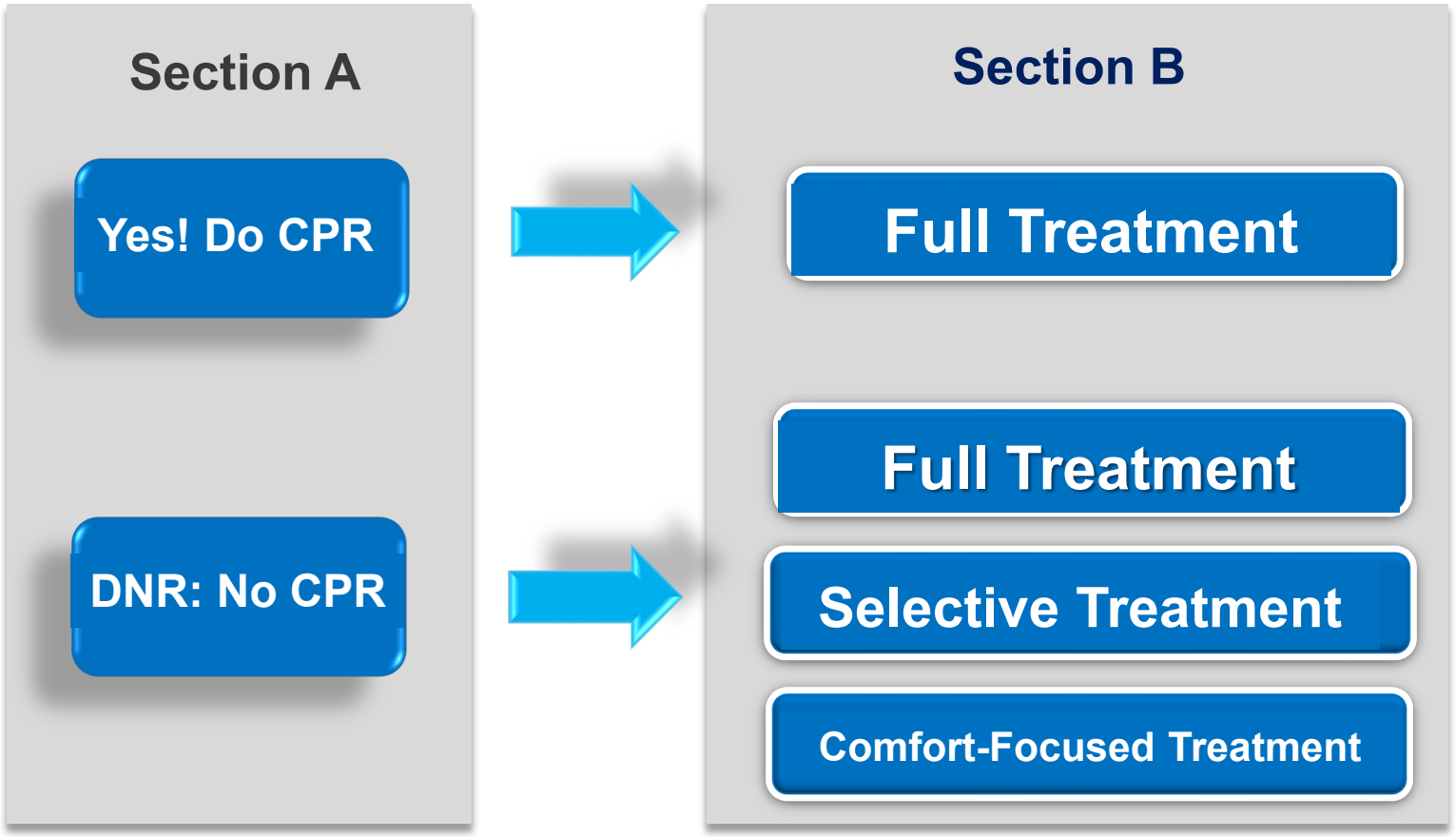
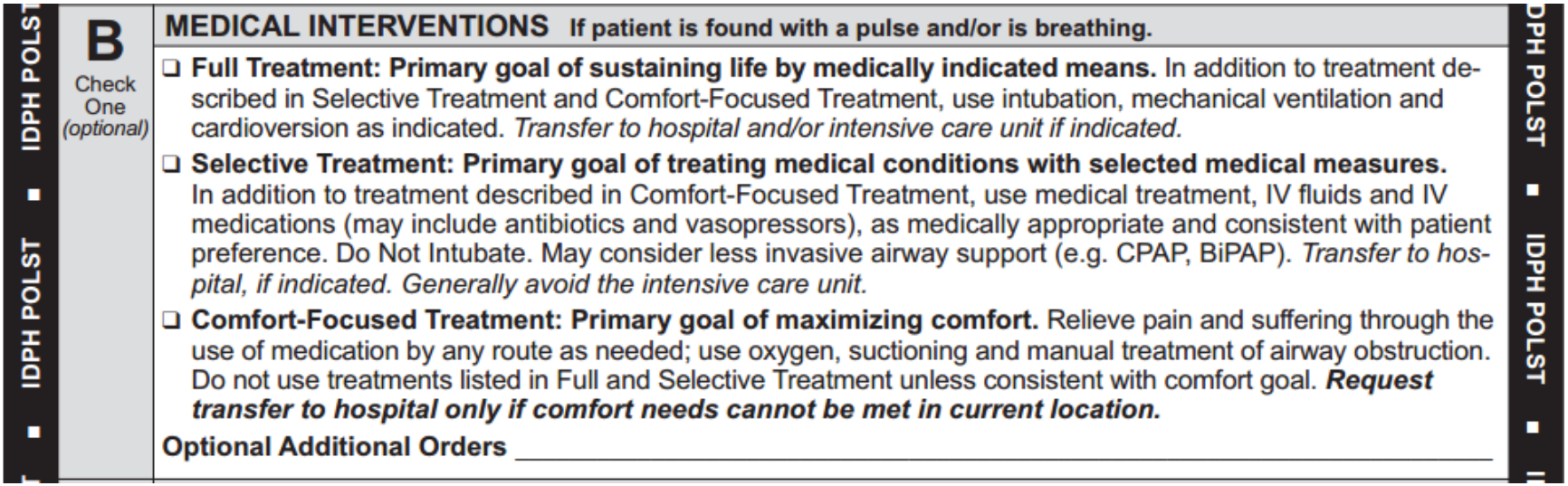
Acceptable Options for a Valid Form



Section “B”: Medical Interventions



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B
Check One *(optional)*

MEDICAL INTERVENTIONS **If patient is found with a pulse and/or is breathing.**

- ❑ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*
- ❑ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*
- ❑ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

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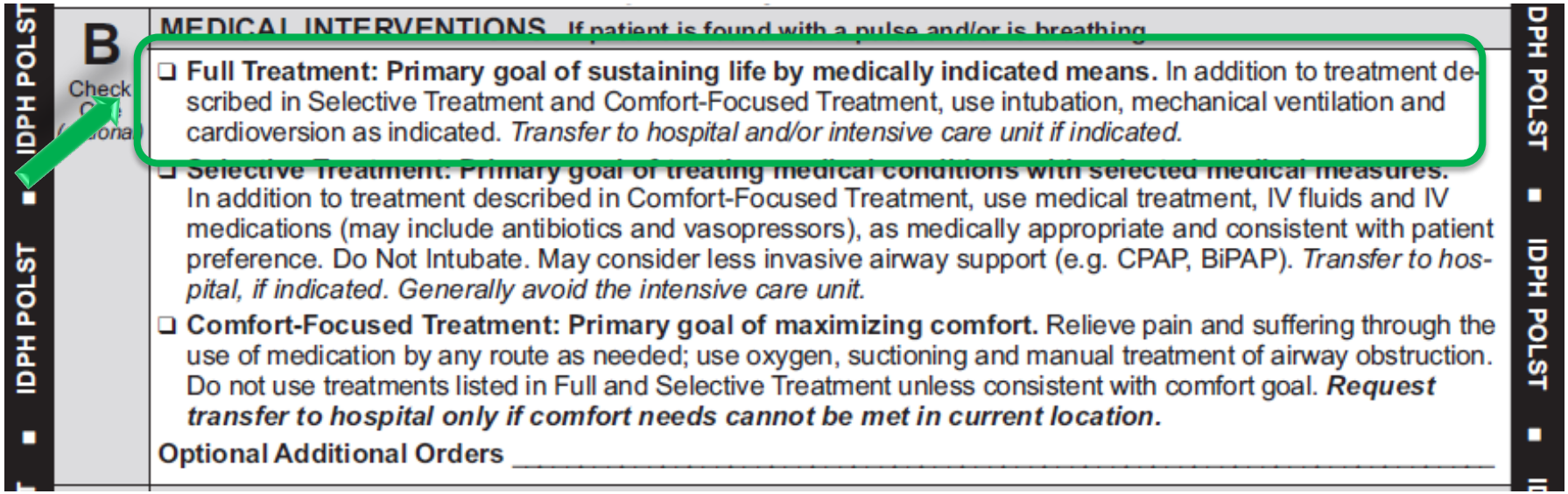
Section B documents what a person wishes to occur if they are found **with a pulse and/or breathing present** but unable to communicate; cardiac arrest may occur shortly.

The checked box explains patient’s goal for treatment and specifies which treatments the patient wants to have and avoid.

Section "B": Medical Interventions



✓ **Full Treatment:** ***Transfer me to the hospital and provide all appropriate treatment. I want to live as long as possible.***

Must be selected when selecting CPR in section A

Either box may be marked in Section A

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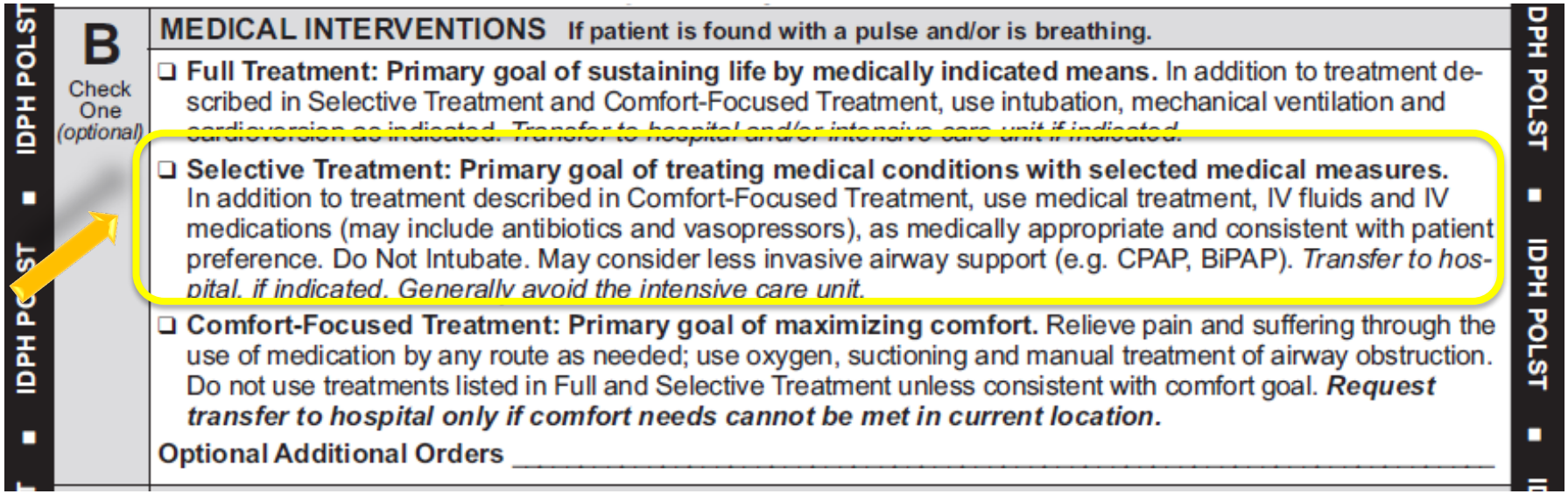
Section "B": Medical Interventions



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B
Check One *(optional)*

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Optional Additional Orders _____

✓ **Selective Treatment*: Transfer me to the hospital for medical treatment, but I do not want to be on the ventilator.***

Person could receive treatments such as:

- IV fluids; IV meds as appropriate
- May use CPAP, BiPAP, BVM
- Other treatments as needed to return to "baseline"

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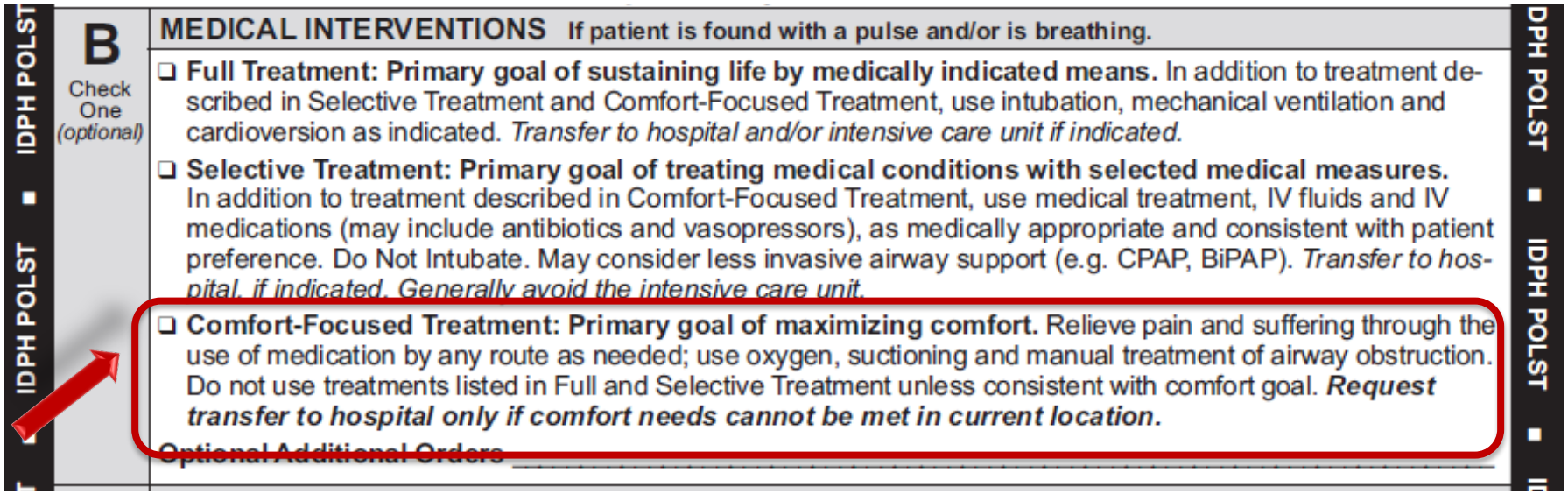
Section "B": Medical Interventions



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B
Check One
(optional)

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Optional Additional Orders _____

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- ✓ **Comfort-Focused Treatment**: *I want to be as comfortable as possible where I am but transfer me to the hospital if my pain or symptoms cannot be alleviated.*

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Section "B": Comfort Focused Treatment

"Comfort-focused treatment" requires a clear explanation to the patient/substitute decision-maker:

- Regardless of the option selected in section B, treatment for comfort is always provided – **we never do nothing!**
- For example, if a person is choking, suction, manual treatment of airway, Heimlich maneuver would be implemented:

Choking is <u>NOT COMFORTABLE</u>!!

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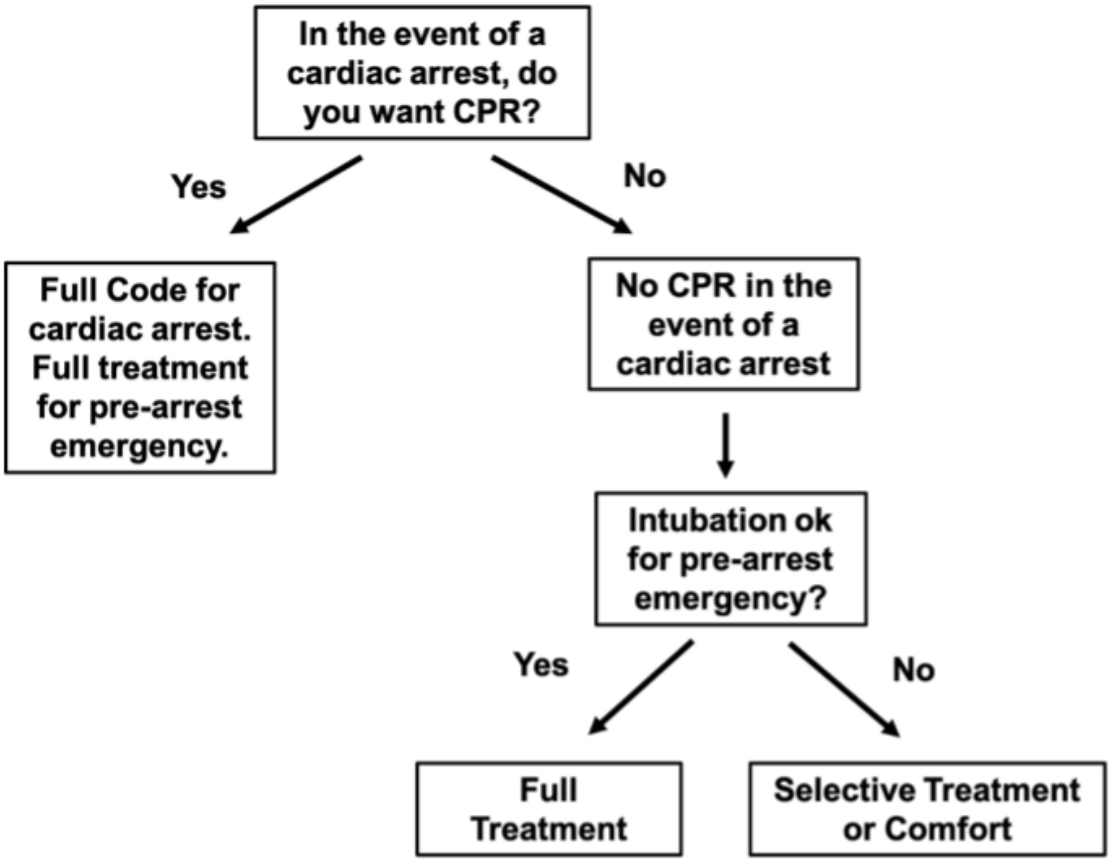
Another way to think about Sections A & B



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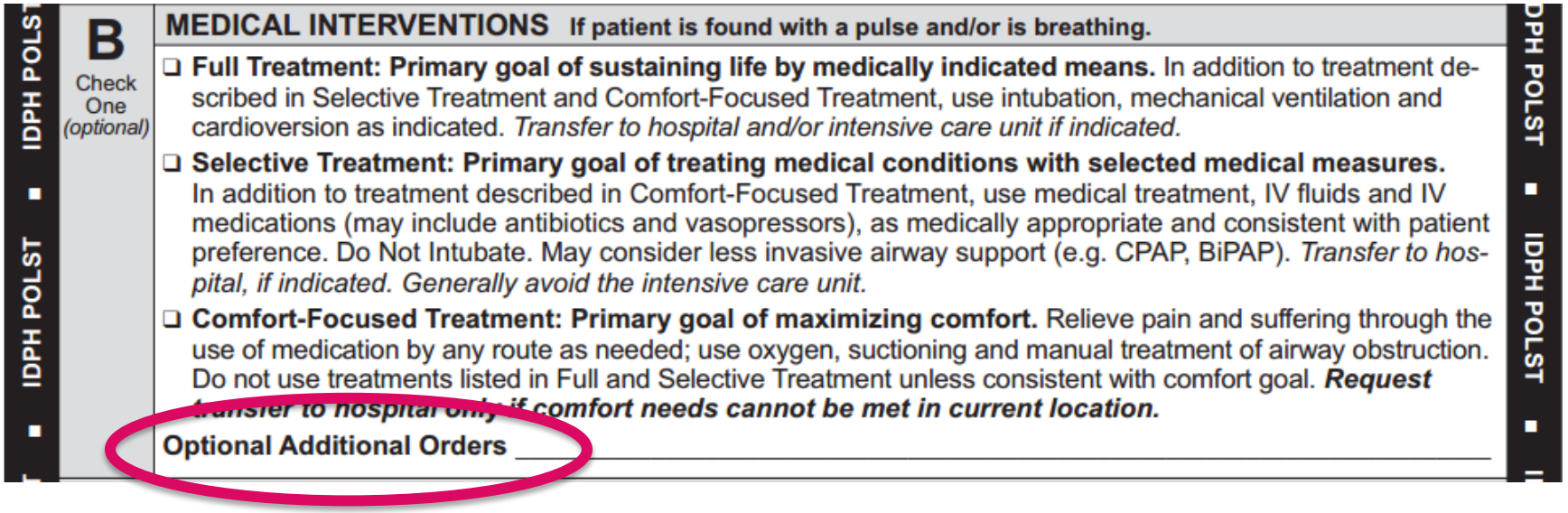
Section “B”: Medical Interventions



IDPH POLST ■ IDPH POLST ■

B
Check One *(optional)*

MEDICAL INTERVENTIONS **If patient is found with a pulse and/or is breathing.**

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Optional Additional Orders _____

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Optional Additional Orders - used to customize form for individual medical conditions when necessary

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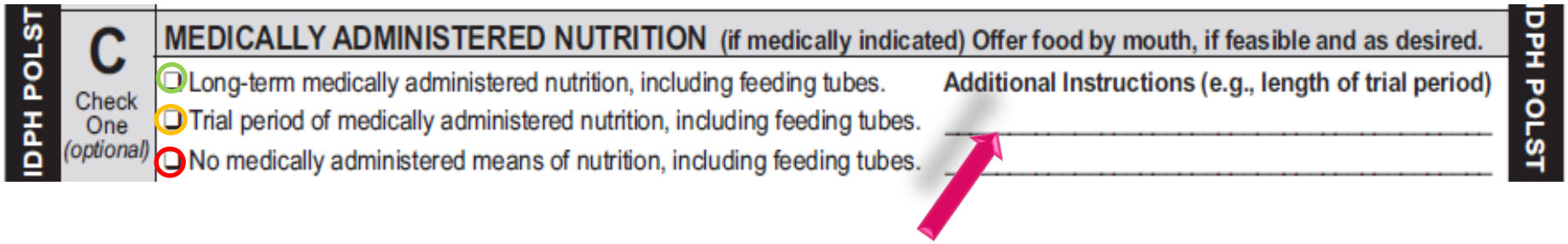
Section C: Medically Administered Nutrition



Although it isn't critical for emergency care, it is very helpful for healthcare providers to know your wishes about feeding tubes, called medically administered nutrition.

- ✓ ***Yes, I do want long-term artificial nutrition if I am no longer able to take foods or liquids by mouth***
- ✓ ***Trial period, I do want artificial nutrition for a trial period (see additional instructions)***
- ✓ ***No, I do not want long-term artificial nutrition if I am no longer able to take foods or liquids by mouth***

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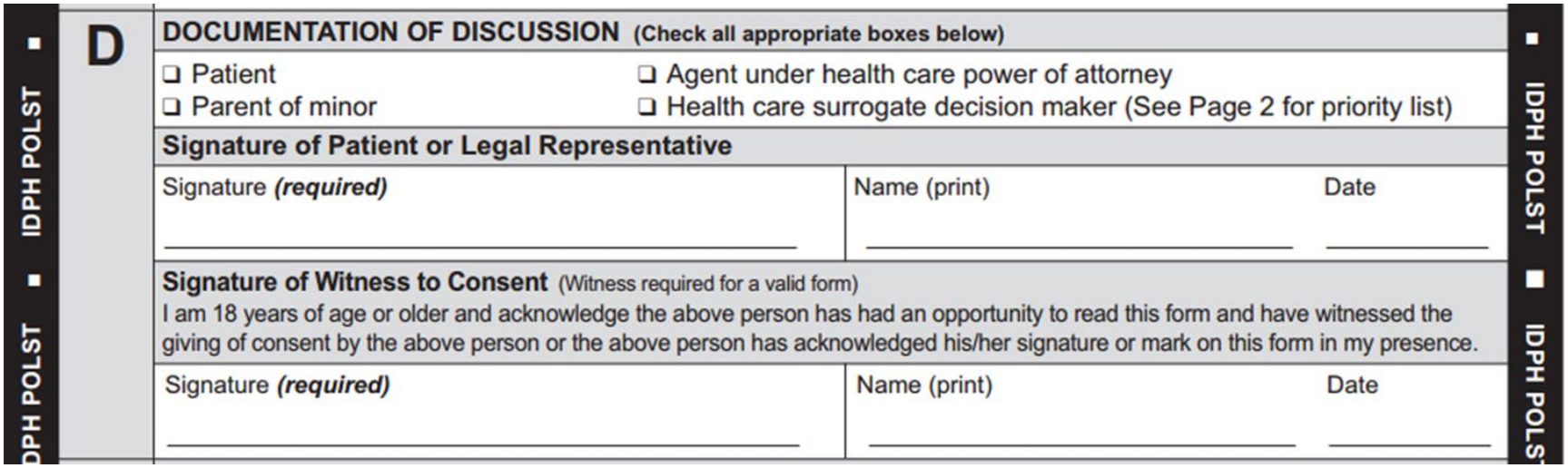
Section D: Documentation of Discussion



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D

DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

- ❑ Patient
- ❑ Parent of minor
- ❑ Agent under health care power of attorney
- ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature *(required)*	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature *(required)*	Name (print)	Date

Need 2 signatures here

- Patient, agent (POAHC), or healthcare surrogate
- Witness to consent

If consented by patient's legal representative, supporting documents verifying agent powers are NOT needed by EMS

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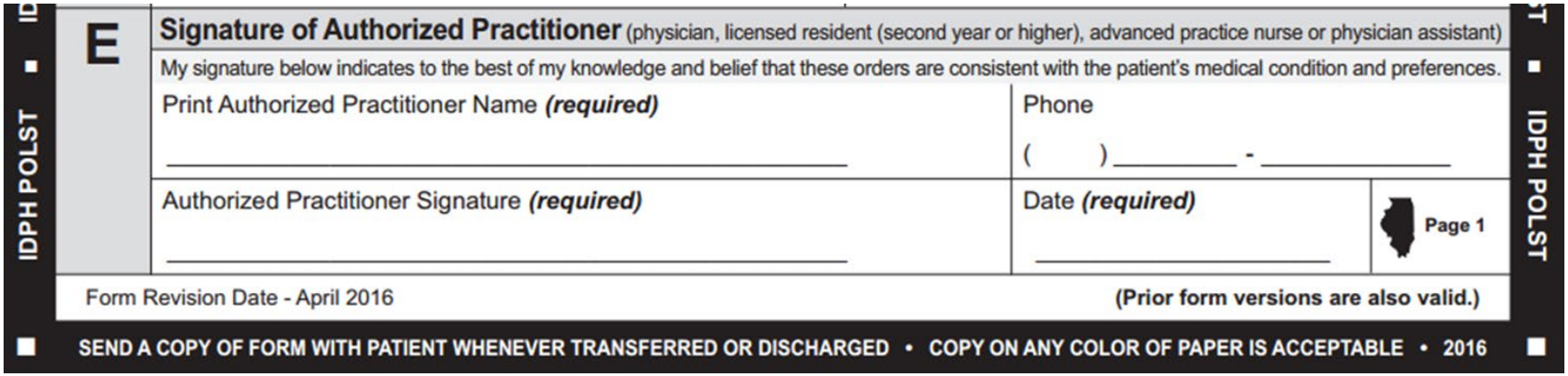
Section E: Signature of Practitioner



IDPH POLST

E **Signature of Authorized Practitioner** (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

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

Print Authorized Practitioner Name ***(required)***

Phone

( ) _____ - _____

Authorized Practitioner Signature ***(required)***

Date ***(required)***

Page 1

Form Revision Date - April 2016

(Prior form versions are also valid.)

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2016

IDPH POLST

Must have practitioner's name, signature, and effective date to be valid. Verbal orders are allowable.

Practitioner's signature may be written by a nurse who adds her/his own initials - acceptable and form is valid

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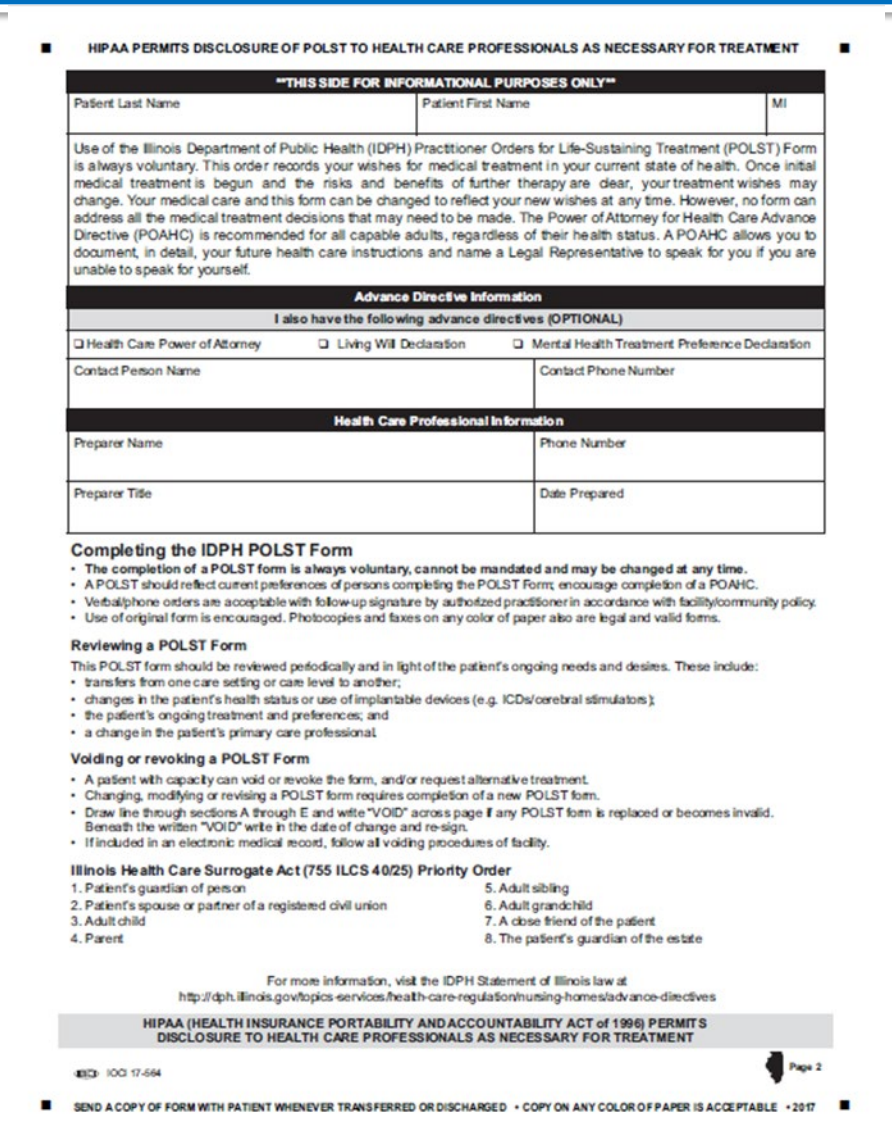
Back Page – EMS does not take action



HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

"THIS SIDE FOR INFORMATIONAL PURPOSES ONLY"

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- **The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g. ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

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SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2017

- Completing the back page of the POLST form is optional
- Form is valid if only first page.
- Information is helpful in identifying next of kin/emergency contact information.

Case 1: Harold

A 75-year-old with late-stage COPD, who when recently hospitalized was intubated and successfully extubated and discharged to home. He is in a physician's office for a follow-up appointment, and the physician has made an ACP referral. Upon conversation with the patient, you learn that the patient understands that should he suffer a cardiac arrest (no breathing, no pulse, unresponsive), the odds of his surviving an attempt at resuscitation are slim, and he does not want to have CPR attempted, However, he is willing to be intubated should he suffer a potentially reversible condition, such as pneumonia, that renders him temporarily unable to breath on his own.

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Case 2: Darrell

60 y/o with metastatic prostate cancer who is able to live at home and manage his own ADL's. He was recently hospitalized, so you initiate a POLST conversation during an office visit. He recognizes that his illness is terminal, and for that reason does not wish to undergo CPR in case of cardiac arrest. He also does not want to be intubated should he suffer a primary respiratory arrest. However, as his quality of life is still good, he is willing to attempt low burden, less-invasive measures to prolong his life.

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Case 3: Ellen

75 y/o woman who has just been diagnosed with early-stage dementia. A POLST conversation is conducted with the patient, and with her permission, her husband, who is her POAHC. She is anxious to document her strong wish that under no circumstances does she want to have artificial nutrition through a tube, even temporarily. She is otherwise in good health, and she expresses to her physician and her husband that should she have a cardiac arrest, she would want an attempt made to resuscitate her.

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Applying the POLST Program

Review and Revision of POLST

- POLST forms should be reviewed and updated periodically when the patient:
  - is transferred to a nursing home or has a significant hospitalization;
  - has a substantial change in clinical condition;
  - changes treatment preferences or goals of care

- The POLST conversation should be repeated before documenting new treatment decisions or confirming current treatment decisions

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POLST in COVID-19 Pandemic

COVID-19 is particularly risky for frail and chronically ill nursing home residents:

- POLST is for a **limited population**: facilities and providers should offer this population the opportunity to have or review a POLST form right away
- Specifically discuss the potential risks and benefits of treatments considering COVID-19, and revise the POLST form if desired
- Document patient treatment preferences even if it may not be possible to honor all preferences depending on available resources
- POLST forms should not have expiration dates even considering COVID-19
- POLST forms can be changed if lower/higher risk of COVID-19 effects goals of care

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NOT Recommended

1. Mandating completion of POLST forms
2. Completing a form without meaningful conversation first
3. Giving a person a POLST form to complete for themselves
4. Completing POLST form without patient/substitute decision-maker knowledge
5. Signing POLST form for patient/substitute decision-maker
6. Never reviewing completed POLST forms

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Valid POLST Forms

- ✓ Properly executed prior versions of the IDPH Uniform DNR or the DNR/POLST Advance Directive are still valid. **Most recently dated is followed.**
- ✓ Photocopies of forms are valid.
- ✓ Picture of POLST form on electronic device is valid.

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Requirements for a Valid POLST Form

REQUIRED

- Patient Identifying Information
- Section A
- 3 Signatures:
  1) Patient or legal substitute decision-maker
  2) Witness
  3) Practitioner
- Date of Practitioner Signature

OPTIONAL

- All other information optional
- All indicated treatment used where a decision is unspecified
- **Pink** paper recommended to enhance visibility, but color does not affect validity of form

QUESTION & ANSWER

POLST Resources

For POLST Illinois information:

polstIllinois@gmail.com

www.polstil.org

National POLST Program

www.polst.org

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Resources for “the conversation”

- https://www.theconversationproject.org/
- https://respectingchoices.org/
- https://www.ariadnelabs.org/areas-of-work/serious-illness-care/resources/#Downloads&%20Tools
- https://pact.northwestern.edu/
- https://www.vitaltalk.org/

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This presentation created by the POLST Illinois Education Committee has been made possible by in-kind and other resources provided by:

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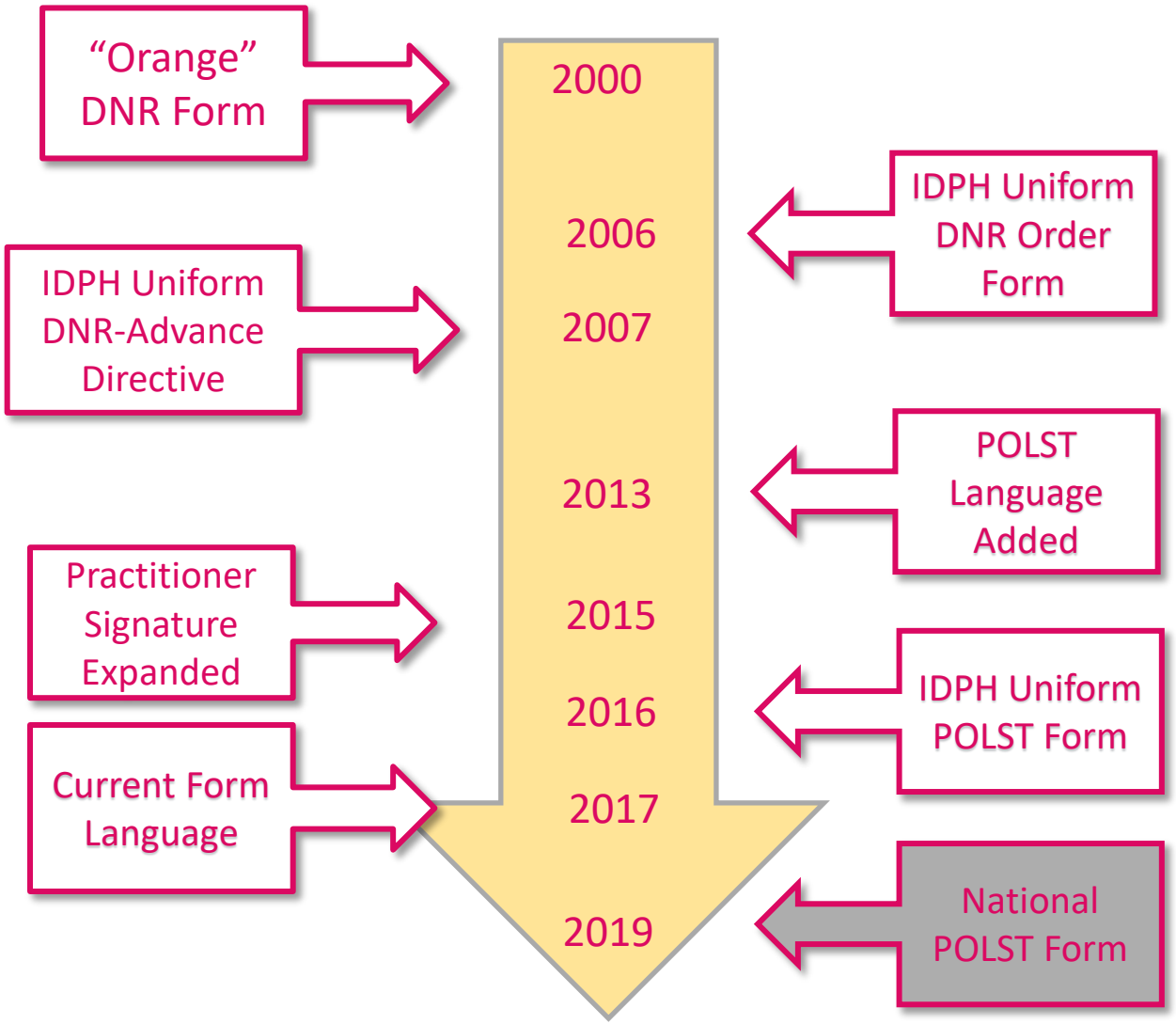
Illinois Hospice & Palliative Care Organization

il-hpco.org

Evolution of the IDPH Uniform POLST Form



Additional Criteria for Evaluating Appropriate Use of POLST

Patients with a serious life-limiting medical condition or advanced frailty:

- whose health care professional would not be surprised if they died within 1-2 years; or
- who are at an increased risk of experiencing a medical emergency based on their current medical condition and who wish to make clear their treatment preferences, including about CPR, mechanical ventilation, ICU; or
- who have had multiple unplanned hospital admissions in the last 12 months, typically coupled with increasing frailty, decreasing function, and/or progressive weight loss.

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National Support for POLST:
Landmark Study JAGS 2014

- Study on the relationship between what POLST orders are selected and where people ultimately die. 18,000 death records (2010-2011) reviewed from Oregon's electronic POLST registry

- **Relationship between options selected on the POLST form and <u>where people die</u>:**
  - **6.4% of persons who had a POLST Form specifying *Comfort Measures Only* treatment wishes died in a hospital**
  - **22.4% for persons who wished for *Limited Additional Interventions* died in a hospital**
  - **44.2% of persons whose POLST specified wishes for *Full Treatment* died in a hospital**
  - **34.2% of persons without a POLST Form died in a hospital**

(Fromme, Erik, et.al., "Association Between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon", JAGS, Vol. 62, No. 7, July 2014, pp 1246–1251.)

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