



**POLST**  
ILLINOIS

Practitioner Orders for  
Life-Sustaining Treatment

Hospital Setting – Form Preparers (Non-Signing) Audience

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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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## POLST Program Overview

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## 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 2<sup>nd</sup> year or higher of residency program



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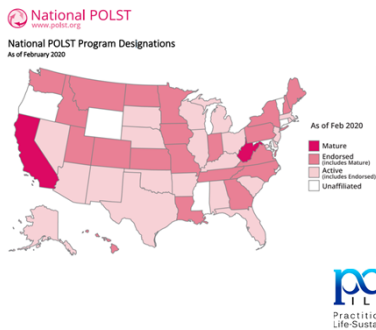
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## Where did POLST come from?



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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

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## 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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### Knowledge GAP - Decision Point

Non-practitioner POLST conversation reveals one or more:

- ✓ Diagnosis/prognosis not understood
- ✓ Family member/s and patient/proxy not on the same page
- ✓ Risks & benefits of POLST treatment options not understood
- ✓ Patient/proxy wishes are significantly different than anticipated
- ✓ Other substantial conflicts arise during the POLST conversation

#### IF YES -

Refer to medical practitioner for additional, appropriate clinical information

#### IF NO –

Continue to discuss POLST Form



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### Case Studies


1. A 60 y/o with metastatic cancer who was recently hospitalized, and a POLST conversation is being conducted before he is discharged home. He recognizes his illness is terminal and 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. **REFER FOR MORE INFO?**
2. A 78 y/o with late-stage COPD and frailty who, while hospitalized, was intubated and successfully extubated. A POLST conversation is conducted with the patient and, with his permission, his brother, who is also the patient's POAHC, before the patient returns to his skilled nursing facility. The patient believes that should he suffer a cardiac arrest, the odds of his surviving an attempt at resuscitation are slim, and he does not wish to have CPR attempted. He is unsure about being intubated again should he suffer a potentially reversible condition, such as a pneumonia, but seems to prefer to stay at the SNF rather than go to the hospital. His brother feels very strongly that the patient should be full code, he survived the ICU once and will again. **REFER FOR MORE INFORMATION?**



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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

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## The IDPH Uniform POLST Form

**1. PATIENT INFORMATION**

Print Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**2. MEDICAL INTERVENTIONS**

**A. Life-Sustaining Treatment**

Do you want to receive life-sustaining treatment if you become unable to make decisions for yourself?

Yes ☐ No ☐ Don't Know ☐

**B. Comfort Measures**

Do you want to receive comfort measures if you become unable to make decisions for yourself?

Yes ☐ No ☐ Don't Know ☐

**C. Artificial Nutrition and Hydration**

Do you want to receive artificial nutrition and hydration if you become unable to make decisions for yourself?

Yes ☐ No ☐ Don't Know ☐

**D. Resuscitation**

Do you want to receive resuscitation if you become unable to make decisions for yourself?

Yes ☐ No ☐ Don't Know ☐

**E. Other Medical Interventions**

Do you want to receive other medical interventions if you become unable to make decisions for yourself?

Yes ☐ No ☐ Don't Know ☐

**3. PROVIDER INFORMATION**

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**4. SIGNATURES**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**5. NOTES**

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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 Check One	<b>A</b>	<b>CARDIOPULMONARY RESUSCITATION (CPR)</b> If patient has no pulse and is not breathing.
	<input type="checkbox"/> Attempt Resuscitation/CPR <small>(Selecting CPR means Full Treatment in Section B is selected)</small>	<input type="checkbox"/> Do Not Attempt Resuscitation/DNR

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.

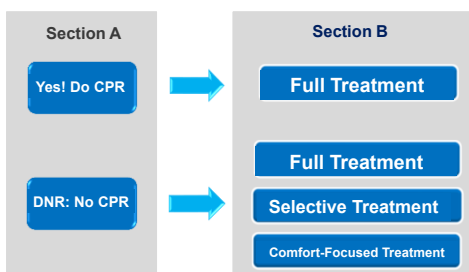


If "DNR" box checked: **Do NOT** begin CPR.



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### Acceptable Options for a Valid Form



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## Section “B”: Medical Interventions

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

Check One (optional)

☐ 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

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.

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## Section “B”: Medical Interventions

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

Check One (optional)

☒ 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.*

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Optional Additional Orders

✓ 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

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

Check One (optional)

☐ 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.*

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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

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

Check One (optional)


☐ 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 desired. 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.*

*System of Additional Orders*

✓ **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 NOT COMFORTABLE!!**



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## Another way to think about Sections A & B

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    Q1[In the event of a cardiac arrest, do you want CPR?] -- Yes --> A1[Full Code for cardiac arrest. Full treatment for pre-arrest emergency.]
    Q1 -- No --> Q2[Intubation ok for pre-arrest emergency?]
    Q2 -- Yes --> A2[Full Treatment]
    Q2 -- No --> A3[Selective Treatment or Comfort]
        
```



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## Section "B": Medical Interventions

**B** 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 if comfort needs cannot be met in current location.

**Optional Additional Orders**

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

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## Section C: Medically Administered Nutrition

**C** 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.

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

**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 \_\_\_\_\_

**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

**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

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

<b>APRIL 2007</b> <b>REGISTRATION INFORMATION AND SIGNATURE</b>			
<b>APPLICANT'S NAME</b> (Last, First, Middle Initial) _____			
<b>DATE OF BIRTH</b> (Month/Day/Year) _____			
<b>EDUCATION</b> (List all the schools, Department of Education, and State in which you have been educated. In the accompanying Education History table, you will be asked to provide details of your education.) _____			
<b>WORK HISTORY</b> (List all the employers, Department of Education, and State in which you have worked. In the accompanying Work History table, you will be asked to provide details of your work history.) _____			
<b>PROFESSIONAL INFORMATION</b> (List all the professional organizations, departments, and states in which you have been involved. In the accompanying Professional Information table, you will be asked to provide details of your professional information.) _____			
<b>APPLICANT'S SIGNATURE</b> (Sign and print your name in the space provided.) _____			
<b>APPLICANT'S ADDRESS</b> (List your current address, including city, state, and zip code.) _____			
<b>APPLICANT'S PHONE NUMBER</b> (List your current phone number, including area code.) _____			
<b>APPLICANT'S EMAIL ADDRESS</b> (List your current email address.) _____			
<b>APPLICANT'S SOCIAL SECURITY NUMBER</b> (List your current Social Security Number.) _____			
<b>APPLICANT'S DATE OF BIRTH</b> (List your current date of birth, including month, day, and year.) _____			
<b>APPLICANT'S SEX</b> (List your current sex.) _____			
<b>APPLICANT'S RACE</b> (List your current race.) _____			
<b>APPLICANT'S ETHNICITY</b> (List your current ethnicity.) _____			
<b>APPLICANT'S RELIGION</b> (List your current religion.) _____			
<b>APPLICANT'S POLITICAL AFFILIATION</b> (List your current political affiliation.) _____			
<b>APPLICANT'S CURRENT EMPLOYER</b> (List your current employer.) _____			
<b>APPLICANT'S CURRENT POSITION</b> (List your current position.) _____			
<b>APPLICANT'S CURRENT SALARY</b> (List your current salary.) _____			
<b>APPLICANT'S CURRENT BENEFITS</b> (List your current benefits.) _____			
<b>APPLICANT'S CURRENT CONTACT INFORMATION</b> (List your current contact information.) _____			
<b>APPLICANT'S CURRENT EDUCATION</b> (List your current education.) _____			
<b>APPLICANT'S CURRENT WORK HISTORY</b> (List your current work history.) _____			
<b>APPLICANT'S CURRENT PROFESSIONAL INFORMATION</b> (List your current professional information.) _____			
<b>APPLICANT'S CURRENT APPLICANT INFORMATION</b> (List your current applicant information.) _____			
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<b>APPLICANT'S CURRENT CURRENT CURRENT BENEFITS</b> (List your current benefits.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT CONTACT INFORMATION</b> (List your current contact information.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT EDUCATION</b> (List your current education.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT WORK HISTORY</b> (List your current work history.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT PROFESSIONAL INFORMATION</b> (List your current professional information.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT APPLICANT INFORMATION</b> (List your current applicant information.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT SIGNATURE</b> (Sign and print your name in the space provided.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT ADDRESS</b> (List your current address, including city, state, and zip code.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT PHONE NUMBER</b> (List your current phone number, including area code.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT EMAIL ADDRESS</b> (List your current email address.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT SOCIAL SECURITY NUMBER</b> (List your current Social Security Number.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT DATE OF BIRTH</b> (List your current date of birth, including month, day, and year.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT SEX</b> (List your current sex.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT RACE</b> (List your current race.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT ETHNICITY</b> (List your current ethnicity.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT RELIGION</b> (List your current religion.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT POLITICAL AFFILIATION</b> (List your current political affiliation.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT CURRENT EMPLOYER</b> (List your current employer.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT CURRENT POSITION</b> (List your current position.) _____			
<b>APPLICANT'S CURRENT CURRENT CURRENT CURRENT SALARY</b> (			

- 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.

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## Case 1: John

A 60-year-old with metastatic prostate cancer who was previously able to live at home and manage his own ADLs. He has been in and out of the hospital frequently, and a Palliative Care consult has been ordered. Upon goals of care conversation with the patient, you learn that he recognizes 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 2: Harold

A 75-year-old with late-stage COPD, who when recently hospitalized was intubated and successfully extubated and is being discharged to home. 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 breathe on his own.



**POLST**  
ILLINOIS  
Practitioner Orders for  
Life-Sustaining Treatment

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## Case 3: Ellen

An 85-year-old woman with advanced dementia who presents to the ED with increased confusion and lethargy. Her husband gives admission staff documents that show he is the POAHC. A social worker referral is placed to discuss health care wishes and plans. You find the husband is anxious to document her strong wishes that under no circumstances does she want to have artificial nutrition through a tube, even temporarily, and she doesn't want to be resuscitated for any reason.



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Practitioner Orders for  
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## Applying the POLST Program

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## Review and Revision of POLST

- POLST forms should be reviewed and updated periodically when the patient:
  - is transferred between ICU and general medical unit;
  - 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 for Organizational POLST Policies

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



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## POLST

# POLST

*Disclaimer: this presentation cannot provide legal advice; it is intended for informational purposes only.*

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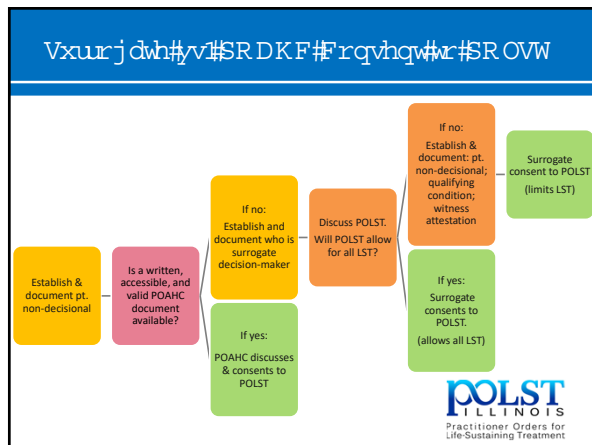
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## Voiding or Changing a POLST

**Patient who regains decisional capacity:**

POLST is no longer consulted.

Patient should revisit POLST conversation and potentially revise form.

**Power of Attorney for Health Care (always) & Surrogate (if no existing POLST):**

Can void and/or complete a new POLST for non-decisional patient as conditions change

Substituted judgement if wishes are known/documented in AD

Best interest of patient if wishes are not known/documented in AD

**Health Care Surrogate if existing POLST consented to by patient themselves:**

Must consult with attending practitioner

Encourage "substituted judgment standard" document in patient's POLST

Document new information known about patient's wishes in EHR

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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	OPTIONAL
Patient Identifying Information	All other information optional
Section A	
3 Signatures: 1) Patient or legal substitute decision-maker 2) Witness 3) Practitioner	All indicated treatment used where a decision is unspecified
Date of Practitioner Signature	<b>Pink</b> paper recommended to enhance visibility, but color does not affect validity of form

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### QUESTION & ANSWER

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## POLST Resources

For POLST Illinois information:

polstllinois@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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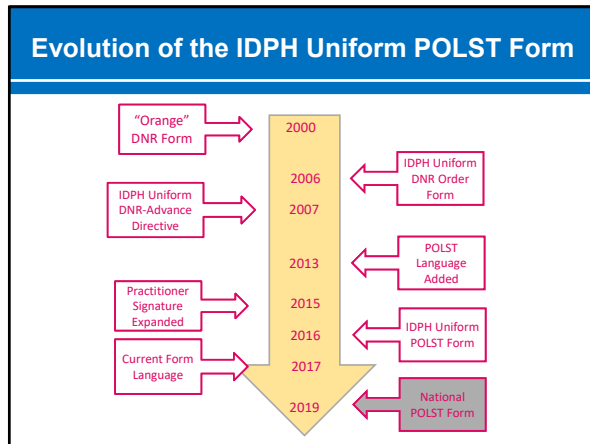
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## Evolution of the IDPH Uniform POLST Form



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## 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 where people die:
  - 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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