Arizona POLST

A Participating Program of National POLST

Frequently Asked Questions for Providers

1. What is the POLST form?

POLST is a medical order that helps give seriously ill patients more control over their end-of-life care. A key component of POLST is thoughtful, facilitated advance care planning conversations between a healthcare provider and patient and those close to them to determine what treatment the patient wants based on their personal beliefs and current state of health. In these conversations' patients are informed of their treatment options and, if they wish, the patient with their healthcare provider completes an POLST form based on the patient's expressed treatment preferences. As a result, POLST can prevent unwanted or medically ineffective treatment, reduce patient and family suffering, and help ensure that the patient's wishes are honored. POLST can also support patients who want to prolong life to the greatest extent possible to receive their desired care.

2. What information is included on the POLST form?

The decisions documented on the POLST form include whether to:

Attempt cardiopulmonary resuscitation
Administer antibiotics and IV fluids
Use intubation and mechanical ventilation
Provide long-term artificial nutrition
Additional orders or instructions

3. Why was POLST developed?

POLST was developed to improve patient care and reduce medical errors by creating a system that identifies patients' wishes regarding medical treatment and communicates and respects them by creating portable medical orders. The system focuses on a growing segment of the United States population, those seriously ill patients with advanced, chronic progressive illness. While we support the completion of advance directives, clinical experience and research demonstrate that these advance directives are not sufficient to assure that those who suffer from serious, advanced, progressive chronic illnesses will have their preferences for treatment honored unless an POLST form is also completed. The purpose of POLST is to provide a framework for healthcare providers so they can deliver the treatments patients want and avoid those treatments they DO NOT want.

4. Is POLST mandated by law?

Patient completion of an POLST form is entirely voluntary.

5. Who should have an POLST form?

Copyright @ 2020 Arizona Hospital and Healthcare Association. All rights reserved.
No part of this publication may be reproduced in any form without permission.

POLST is designed for seriously ill patients or those who are medically frail. A POLST form should only be used when the patient is considered to be at risk for a life threatening clinical event because they have a serious life-limiting medical condition and the healthcare provider would not be surprised if they died within 1-2 years.

6. Does the POLST form replace traditional Healthcare Directives or the Prehospital Medical Care Directive (orange form)?

No, the POLST form is a portable medical order set, not a Healthcare Directive. The POLST form complements a Healthcare Directive, including the Prehospital Medical Care Directive, and is not intended to replace these documents. A Healthcare Directive is still necessary to appoint a legal healthcare agent or surrogate and is recommended for all adults, regardless of their health status. The Prehospital Medical Care Directive gives emergency medical services (EMS) providers' direction. A Prehospital Medical Care Directive should still be completed for people who choose "Do Not Resuscitate."

7. If someone has an POLST form and a Healthcare Directive that conflict, which takes precedence?

Currently under Arizona Law, if there is a conflict between the documents, the healthcare directive should be followed. Healthcare providers should periodically review all documents with the patient and caregiver to ensure they are in alignment with the patient's goals of care. To reduce chance of conflict it is recommended the healthcare directive and POLST form be reviewed to ensure no conflict exists and attached together. If there is a conflict between the written documents a conversation should occur to identify the patient's treatment wishes or known treatment wishes and all documents updated.

8. Who should discuss and complete the POLST form with patients?

Having a conversation with a patient about end-of-life issues is an important and necessary part of good medical care. Anyone who is a healthcare provider***** can assist with the completion of an POLST form. In many cases, providers will initiate conversations with their patients to understand their wishes and goals of care. Depending on the situation and setting, other trained staff members – such as nurses, social workers, or chaplains – may also play a role in starting the POLST conversation. However, a physician, nurse practitioner, or physician's assistant must always confirm the patient's or surrogate's wishes and sign the form.

*****The term "healthcare provider" is defined by law as "an individual licensed, certified, or otherwise authorized or permitted by the law of this state to provide healthcare in the ordinary course of business or practice of a profession."

9. Can an POLST form be completed for patients who can no longer communicate their treatment wishes?

Copyright @ 2020 Arizona Hospital and Healthcare Association. All rights reserved.
No part of this publication may be reproduced in any form without permission.

Yes. A healthcare agent or surrogate decision maker can complete the POLST form based on understanding of the patient's wishes. The appointed healthcare agent or surrogate can then sign the POLST form on behalf of the patient.

10. What should be done with POLST after it is completed and signed?

The original POLST form should be printed on bright pink paper and should stay with the patient at all times. If the patient is transferred to another setting, the POLST form should go with them.

- In the acute care or long-term care setting, the form should be kept in the patient's medical record or file.
- At home, patients should be instructed to place the form in a visible location so it can be found easily by emergency medical personnel – usually on a table near the patient's bed or on the refrigerator.
- A copy should be entered into the healthcare providers electronic medical record and sent to the Arizona Healthcare Directive Registry with their Living Will.

11. Can a patient's POLST form be changed?

Yes, the POLST can be modified or revoked by a patient and their healthcare provider, verbally or in writing, at any time. Changes can also be requested by a patient's healthcare agent or surrogate, based on new information or changes in the patient's condition.

12. When should a patient's POLST form be reviewed?

It is good clinical practice to review a patient's POLST form when any of the following occurs:

- The patient is transferred from one medical or residential setting to another
- There is a significant change in the person's health status, or there is a new diagnosis
- The patient's treatment preferences change

13. How can I obtain copies of the POLST form to use with patients/clients?

Arizona uses the National POLST form. The form can be found on the Arizona POLST website here or by contacting us at azpolst.org.

14. Are faxed copies and/or photocopies valid? Must pink paper be used?

Faxed copies and photocopies are valid. Ultra-pink paper is preferred and used to distinguish the form from other forms in the patient's medical record; however, the form will be honored on any color of paper.

15. Is the POLST form available in other languages?

Copyright @ 2020 Arizona Hospital and Healthcare Association. All rights reserved.
No part of this publication may be reproduced in any form without permission.

Once the POLST form is final, it will be translated into other languages as needed.

16. Where is POLST being used now?

POLST exists at some level in 50 states and Washington DC: *Existing* is a spectrum from just having legislation passed, to implementing POLST with regional pilots, to having implemented POLST so it is standard of care within that state. The POLST form is called by differing names depending on the state. For example, in New York it is called a MOLST form, in Colorado a MOST form, and in West Virginia a POST form. In 2019, National POLST participating states worked to standardize the form with the intent it would reduce confusion, provide standardization and make it easier for people moving between states. Arizona formally adopted and implemented the National POLST Form, it is called POLST, a portable medical order. The form is currently being used in Arizona. For more information on where POLST is being used visit the National POLST website at www.poslt.org.

17. Will a patient's POLST form be valid when traveling to another state?

Whether a POLST form will be honored in another state is determined by the laws of that state. A valid POLST form presented to a healthcare provider in another state will likely carry a great deal of weight as a strong indication of patient preferences with the endorsement of the healthcare provider who signed the form; however, providers in other states might not be obliged to follow the orders. If patients are traveling outside Arizona, it is a good idea for them to take both their Healthcare Directive and POLST form with them. Both documents, even if not legally binding, will help healthcare providers know and honor the patient's wishes.

18. Who is leading the POLST initiative in Arizona?

Thoughtful Life Conversations (TLC), a program of the Arizona Hospital and Healthcare Association, provides leadership and oversight for POLST outreach activities in Arizona, with support from many partners throughout the state. To learn more about POLST education visit ArizonaPolst.org.

19. How can I find out more about POLST?

Visit the POLST website at www.POLST.org for additional information and resources.

Copyright @ 2020 Arizona Hospital and Healthcare Association. All rights reserved.
No part of this publication may be reproduced in any form without permission.

20. **What are the different life care planning documents for patients?**

	Patient Signature	Healthcare Provider Signature	Witness or Notary
A Healthcare power of attorney is a legal document where you choose **another person** to make future healthcare decisions for you if you become too ill or cannot make those decisions for yourself.	X		X
A **Durable Mental Healthcare Power of Attorney** is a legal document used if you want to appoint a person to make future mental healthcare decisions for you if you become incapable of making those decisions for yourself.	X		X
A Living Will is a written statement that expresses your wishes about medical treatment that would delay death from a terminal condition, persistent vegetative state or irreversible coma. A Living Will speaks for you in the event you were unable to communicate. It gives direction and guidance to others but is not as broadly applicable as a Healthcare Power of Attorney. For example, a Living Will does not permit healthcare providers to stop tube feeding; only an POLST form, an agent appointed by a Durable Healthcare Power of Attorney or court-appointed guardian may make such a decision.	X		X
POLST is designed for seriously ill patients or those who are medically frail. It is a medical order signed by the patient and the patient's healthcare provider after they have had an advance care planning conversation on treatment options and patient preferences. As a medical order, POLST is actionable across the continuum of care, for example, from the hospitals to nursing homes and the home setting. It is recommended that POLST forms are printed on bright pink paper.	X	X	
A Prehospital Medical Directive (Do Not Resuscitate, DNR or "Orange Form") is a document signed by the healthcare provider and the patient that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate. This form is most appropriate for seriously ill patients or those who are medically frail. DNRs are required to be printed on orange paper.	X	X	X

Copyright @ 2020 Arizona Hospital and Healthcare Association. All rights reserved.
No part of this publication may be reproduced in any form without permission.