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CATHOLIC CHARITIES
HAWAI'I
CIRCLE OF CARE FOR DEMENTIA

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Let's Talk Story!!

Advance Care Planning and Dementia

Kōkua Mau

Hope Young

Advance Care Planning Coordinator

Who is *Kōkua Mau*?

- 501(c)3, community benefit org., statewide (not a state agency)
- Membership –health plans—including HMSA, hospitals, long term care, Senior living communities, churches, temples, hospices, home health agencies, and individuals
- Passionate volunteers across the state

Three areas of activity

1. Work with people who may be facing serious illness & their loved ones to understand the decisions they may need to make – as early as possible!
2. Provide professional networking & training
3. Change the System - Policy & Legislation




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Kokua Mau Resources:

- <https://kokuamau.org/kokua-mau-resources/advanced-dementia-resources-and-issues/>



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HOME COVID-19 ▾ EVENTS ▾ OUR SERVICES ▾ RESOURCES ▾ FOR PROFESSIONALS ▾ MEMBERSHIP ▾ ABOUT ▾

LANGUAGES ▾

Advanced Dementia Resources and Issues

For many who have cared for someone living with dementia, it's called "the long good bye." Caregivers are grieving the loss of their loved one while they're still alive, prolonging and complicating the grief process. Often the person can linger for many years in an advanced dementia stage, immobile and unable to care for him or herself, in need of 24/7 care. At this point, because there is no cure, good palliative care improves quality of life immeasurably – having good person-centered care, love, and gentle touch.

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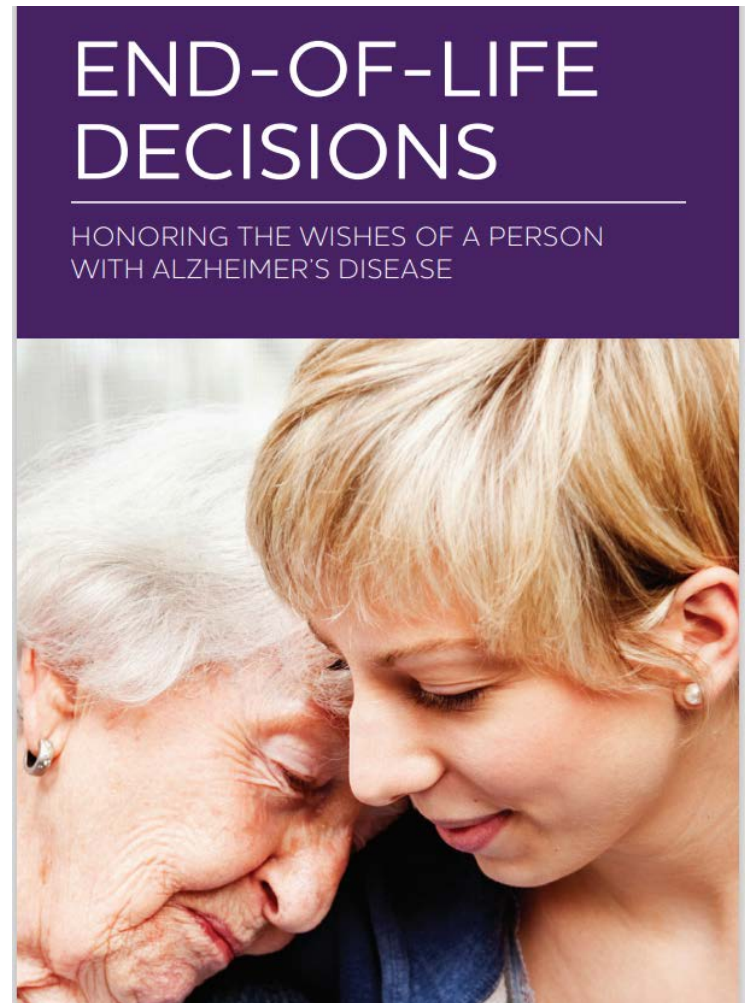
QUICK LINKS

- ▀ [Advance Care Planning](#)
- ▀ [Advance Directives](#)
- ▀ [POLST](#)
- ▀ [Let's Talk Story Program](#)
- ▀ [Palliative Care in Hawaii](#)
- ▀ [Hospice Providers in Hawaii](#)

Privacy -

Alzheimer's Association Resource

https://www.alz.org/national/documents/brochure_endoflifedecisions.pdf



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Alzheimer's Art

<https://art-sheep.com/people-with-alzheimers-see-younger-reflections-of-themselves-in-the-mirror/>



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Articles on ACP specific to dementia considerations :

- <https://acpdecisions.org/advance-care-planning-for-patients-with-alzheimers-disease/>
- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6393818/>



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www.glasbergen.com



**“Communicating with dead people is easy.
Communicating with live people is hard!”**



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A Movement for Change

Kōkua Mau is leading a *movement* that aims to make advance care planning and open communication about care and support for those with serious illness and their loved ones, including end-of-life care

the cultural norm

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

~Woody Allen



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Goals

- Importance of Advance Care Planning
- Having “The Conversation”
- Completing Advance Directives
- Learn tools and tactics for having “the Conversation”

What is Advance Care Planning?



On going process of
Thinking about
Talking about
Writing down
And Sharing

your health care wishes
And who will honor those wishes

Advance Care Planning

Why is it important?

- **COVID 19 has changed the way care is provided in hospitals and doctor's offices**
- No one knows when they may become "Very ill"
- Helps companions to find their voice
- Helps prepare the member and their family for what's coming
- Ease the burden for others having to make tough choices
- Helps assure their wishes are followed



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Without Advance Planning

- Crisis-driven care, reactive and unplanned for
- We risk medical error by providing unwanted care
- Family and health care team have to translate what they THINK is wanted rather than is WANTED



Why Should We Plan Ahead?

- In a retrospective study, those with an advance directive were less likely to:
 - Die in hospital
 - Receive a feeding tube
 - Use a ventilator in last month of life

Teno et al, 2007, JAGS

Why Should We Plan Ahead?

- In controlled trials, Advance Care Planning has been shown to:
 - Reduce hospitalization and cost
 - Improve patient and family satisfaction
 - Reduce survivor stress, depression, anxiety
 - Have no impact on mortality

Molloy et al, 2000, JAMA

Detering et al, 2010, BMJ

HURRICANE PREPAREDNESS

- * Be Prepared**
- * Stay Informed**
- * Take Action**
- * Maintain Contact**



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A public engagement campaign dedicated to assure
that everyone's wishes for end-of-life care are
expressed and respected.

the conversation project

<https://kokuamau.org/the-conversation-project/>

the conversation project

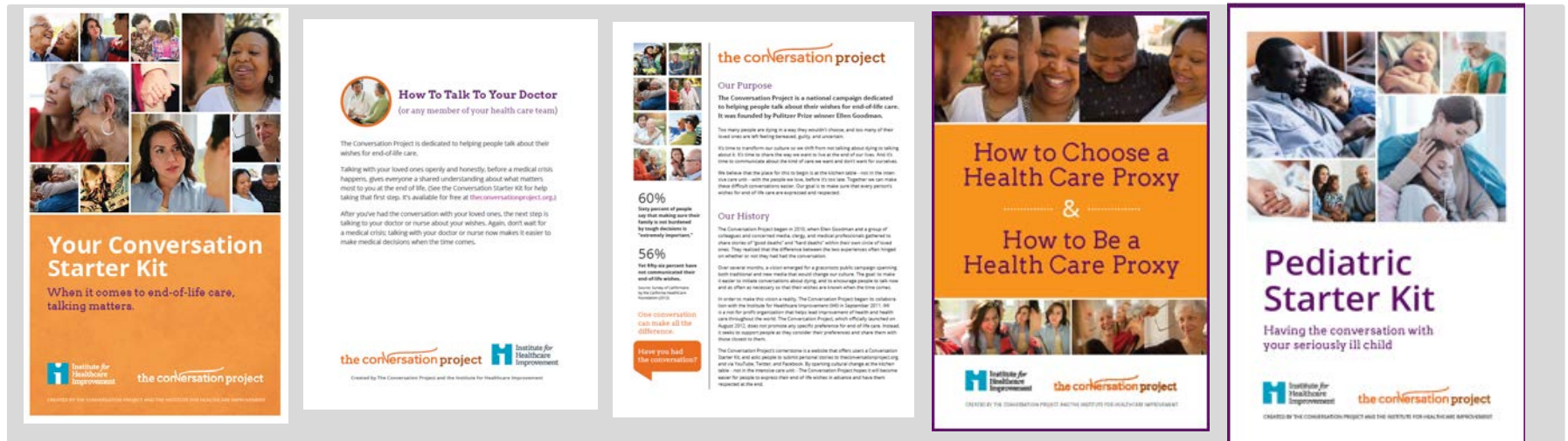


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Accessible: TCP Tools

- Conversation Starter Kit (translations + EMR summary)
- How to Talk to Your Doctor Starter Kit
- Starter Kit for Parents of Seriously Ill Children
- Dementia/Alzheimer's Disease Starter Kit
- How to choose/be a health care agent



the conversation project

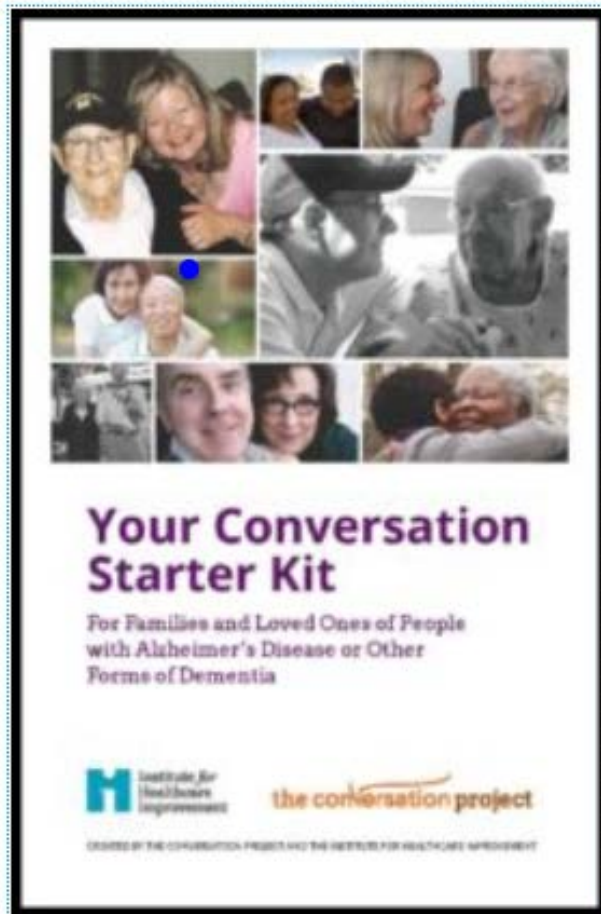


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Additional Tools Available:

<https://theconversationproject.org/starter-kits/>



WORKBOOK

What Matters to Me

A Guide to Serious Illness Conversations

NAME

DATE



the conversation project

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Being Prepared in the Time of COVID-19

Three Things You Can Do Now

This is a challenging time. There are many things that are out of our control. But there are some things we can do to help us be prepared – both for ourselves and the people we care about. Here are three important things each of us can do, right now, to be prepared.

1 Pick your person to be your health care decision maker

Choose a health care decision maker (often known as a proxy, agent, or health care power of attorney) – a person who will make medical decisions for you if you become too sick to make them for yourself.

- Meet in person, if possible, to help you choose a health care decision maker.

Have a talk with your health care decision maker to make sure they know what matters most to you.

- Write a letter to tell your decision maker what matters most to you. Please write in a clear, simple way so your decision maker will understand it.

Fill out an official form naming your health care decision maker. Give one copy of the filled-in form to your decision maker and one copy to your health care team.

- Get a health care proxy form from your doctor, hospital, or advanced care planning agency. You can also find one online.
- Ask your doctor, hospital, or advanced care planning agency for help with the form. They can help you fill it out and make sure it's done right.

2 Talk about what matters most to you

Talk with your important people and decision maker about what matters most.

- The *Conversation Project* has a worksheet you can use to help you think about what matters most.
- If you have already completed the *Conversation Project* worksheet, you can use it to help you think about what matters most to you.

After you talk to your loved ones about what matters, write it down.

- Write down what matters most to you. You can write it down on a piece of paper, or you can use the *Conversation Project* worksheet.

ARIADNE LABS the conversation project

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The Starter Kit

Step 1 Get Ready

You will have many questions as you get ready for the conversation. **Here are two to help you get started:**

- ? What do you need to think about or do before you feel ready to have the conversation?

- ? Do you have any particular concerns that you want to be sure to talk about? (For example, making sure finances are in order; or making sure a particular family member is taken care of.)

The Starter Kit

Step 2 Get Set

What's most important to you as you think about how you want to live at the end of your life? What do you value most? **Thinking about this will help you get ready to have the conversation.**

- ?** Now finish this sentence: **What matters to me at the end of life is...**
(For example, being able to recognize my children; being in the hospital with excellent nursing care; being able to say goodbye to the ones I love.)



What Matters to Me...

- *“I want to say goodbye to everyone I love, have one last look at the ocean, listen to some 90’s music, and go.”*
- *“A tingling sensation of sadness combined with gratitude and overflowing love for what I leave behind.”*
- *“Paced (and with enough space and comfort so that I can make it a ‘quality chapter’ in my life.) I want time and help to finish things.”*
- *“Having my sheets untucked around my feet!”*
- *“Peaceful, pain-free, with nothing left unsaid.”*
- *“In the hospital, with excellent nursing care.”*

The Starter Kit: Get Set

Where I Stand Scales

Use the scales below to figure out how you want your end-of-life care to be. Select the number that best represents your feelings on the given scenario.

As a patient, I'd like to know...

☐ 1

Only the basics
about my condition
and my treatment

☐ 2

☐ 3

☐ 4

☐ 5

All the details about
my condition and
my treatment

As doctors treat me, I would like...

☐ 1

My doctors to do what
they think is best

☐ 2

☐ 3

☐ 4

☐ 5

To have a say in
every decision

If I had a terminal illness, I would prefer to...

☐ 1

Not know how
quickly it is
progressing

☐ 2

☐ 3

☐ 4

☐ 5

Know my doctor's
best estimation for
how long I have to live

3

The Starter Kit: Step 3 Go

MARK ALL THAT APPLY:

? WHO do you want to talk to?

- | | |
|---|---|
| <input type="checkbox"/> Mom | <input type="checkbox"/> Faith leader (Minister, Priest, Rabbi, Imam, etc.) |
| <input type="checkbox"/> Dad | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Child/Children | <input type="checkbox"/> Doctor |
| <input type="checkbox"/> Partner/Spouse | <input type="checkbox"/> Caregiver |
| <input type="checkbox"/> Sister/Brother | <input type="checkbox"/> Other: <input type="text"/> |

? WHEN would be a good time to talk?

- | | |
|--|---|
| <input type="checkbox"/> The next holiday | <input type="checkbox"/> Before the baby arrives |
| <input type="checkbox"/> Before my child goes to college | <input type="checkbox"/> The next time I visit my parents/ adult children |
| <input type="checkbox"/> Before my next trip | <input type="checkbox"/> At the next family gathering |
| <input type="checkbox"/> Before I get sick again | <input type="checkbox"/> Other: <input type="text"/> |

Go Wish Cards

www.GoWish.org



Very Important	Somewhat Important	Not Important
To have my family with me	To have a nurse I feel comfortable with	To take care of unfinished business with family and friends

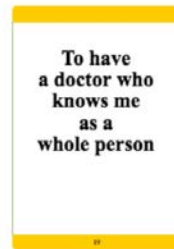


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Go Wish Digital Version

www.gowish.org



Show Instructions

Save This Session

Load Previous Session

Print This Session

Clear/Restart Session

Very Important	To feel that my life is complete	To be free from anxiety	To remember personal accomplishments	To be kept clean	To be free from pain						
Somewhat Important	To meet with clergy or a chaplain	Not being short of breath	To have close friends near								
Not Important											



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Initiating “The Conversation”

- Remind loved ones, “**Everyone over the age of 18** should have an Advance Directive which appoints a Health Care Agent”
- There are no right or wrong answers
- Completing the document and having the conversation with loved ones allows loved ones to support the person’s wishes for care
- It’s a starting point, nothing is set in stone, it can be changed at any time
- “These conversations help us know how to care for each other”

Initiating “The Conversation” (cont.)

- Sometime it is easier initiate the conversation around things the person might ***not*** want, rather than to ask what they **would** want.
- Consider what was important to the person prior to cognitive impairment

Remember during the Pandemic, care is provided differently in hospital settings.

If the unexpected happened,



Who would speak for you?

Would they know what you would want?

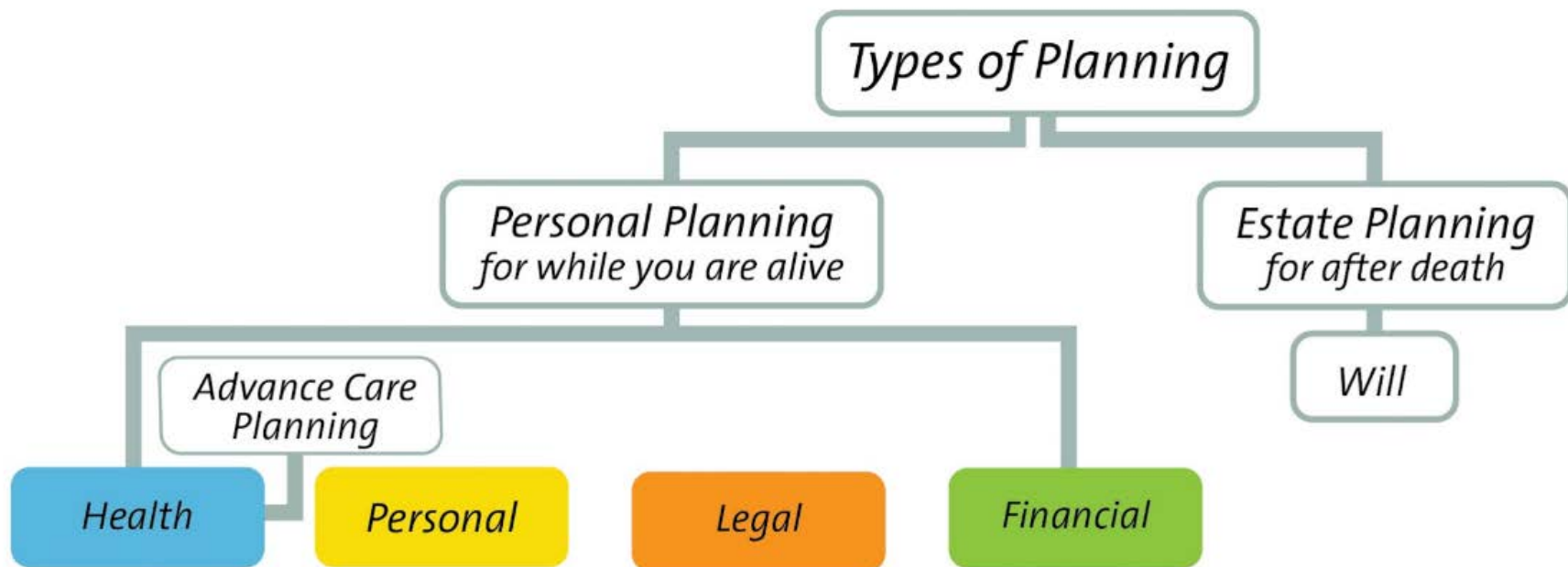


Or possibly what you would not want?

Did you know...

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

Cover all your bases!



Source: Nidus Personal Planning Resource Centre and Registry

Advance Health Care Directive

HAWAII ADVANCE HEALTH CARE DIRECTIVE

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

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

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

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

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

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

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

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

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

A. END OF LIFE DECISIONS

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

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

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

OR

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

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

HAWAII ADVANCE HEALTH CARE DIRECTIVE

My name is:

Last First Middle initial Date of Birth Date

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

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

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

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

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

AHCD – Part 2

Section A: End of Life Decisions

Becomes effective only when:

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

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

A. END OF LIFE DECISIONS

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

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

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

OR

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

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent Page 1 of 3

Choice – Prolong or Not to Prolong Life

- “ I want to stop or hold medical treatment that would prolong my life”

OR

- “I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards”

AHCD – Part 2

Section B: Artificial Nutrition & Hydration

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

B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

___ ☐ If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

C. RELIEF FROM PAIN:

___ ☐ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. OTHER

___ ☐ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

Artificial Nutrition and Hydration: Important considerations

- Individual and personal decision.
- In some illnesses (e.g. stroke, esophageal/throat cancer) artificial nutrition can prolong life.
- In others (Parkinson's, dementia, terminal cancer) artificial nutrition may not prolong life.
- Tube feedings are not recommended for those with dementia. See the official statement at [\[link\]](#)

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
- Electronic notary possible in COVID pandemic

Next Steps:

- Give copies of your completed Advance Directive to:
 - Your health care agent(s)
 - Your provider and/or preferred health system
 - Keep a copy readily available
 - Share with loved ones
 - Share who you chose to be an agent with loved ones
 - Designate on your driver's license and/or HI state ID that you have an Advanced Health Care Directive
 - Review regularly and update as needed

It's a good day!

Mom has mild cognitive impairment, but it has gotten worse over the years. Today, Mom is having a great day, reminiscing, telling stories, it's such a joy! I wish she had more of these days.

- Take the opportunity to film Mom with your phone
- Take the opportunity to have “the conversation” and record it for yourself and loved ones

What is POLST?

- Provider
- Orders for
- Life
- Sustaining
- Treatment

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

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

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

A CARDIOPULMONARY RESUSCITATION (CPR): **** Person has no pulse and is not breathing ****
Check One
☐ Attempt Resuscitation/CPR (Section B: Full Treatment required) ☐ Do Not Attempt Resuscitation/DNAR (Allow Natural Death)

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

B MEDICAL INTERVENTIONS: **** Person has pulse and/or is breathing ****
Check One
☐ Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Transfer if comfort needs cannot be met in current location.**
☐ Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). **Transfer to hospital if indicated. Avoid intensive care.**
☐ Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. **Transfer to hospital if indicated. Includes intensive care.**
Additional Orders: _____

C ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquid by mouth if feasible and desired.
Check One
(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 SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:
Check One
☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below:
☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate
☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.
Print Provider Name: _____ Provider Phone Number: _____ Date: _____
Provider Signature (required): _____ Provider License #: _____

Signature of Patient or Legally Authorized Representative
My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.
Signature (required): _____ Name (print): _____ Relationship (write "self" if patient): _____
Summary of Medical Condition: _____ Official Use Only: _____


SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED



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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 ** <input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNAR (Allow Natural Death) (Section B: Full Treatment required) If the patient has a pulse, then follow orders in B and C
B Check One	MEDICAL INTERVENTIONS: ** Person has pulse and/or is breathing ** <input type="checkbox"/> Comfort Measures Only: Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Transfer if comfort needs cannot be met in current location.</i> <input type="checkbox"/> Limited Additional Interventions: Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). <i>Transfer to hospital if indicated. Avoid intensive care.</i> <input type="checkbox"/> Full Treatment: Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. <i>Transfer to hospital if indicated. Includes intensive care.</i> Additional Orders: _____
C Check One	ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquid by mouth if feasible and desired. (See Directions on next page for information on nutrition & hydration) <input type="checkbox"/> No artificial nutrition by tube. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. Goal: _____ <input type="checkbox"/> Long-term artificial nutrition by tube. Additional Orders: _____
D Check One	SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with: <input type="checkbox"/> Patient or <input type="checkbox"/> Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below: <input type="checkbox"/> Guardian <input type="checkbox"/> Agent designated in Power of Attorney for Healthcare <input type="checkbox"/> Patient-designated surrogate <input type="checkbox"/> Surrogate selected by consensus of interested persons (Sign section E) <input type="checkbox"/> Parent of a Minor Signature of Provider (Physician/APRN licensed in the state of Hawai'i.) My signature below indicates 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: <input type="checkbox"/> M <input type="checkbox"/> 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)							
 <p>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.</p>	<table border="1"> <tr> <td colspan="2">Patient's Last Name</td> </tr> <tr> <td colspan="2">First/Middle Name</td> </tr> <tr> <td>Date of Birth</td> <td>Date Form Prepared</td> </tr> </table>	Patient's Last Name		First/Middle Name		Date of Birth	Date Form Prepared
Patient's Last Name							
First/Middle Name							
Date of Birth	Date Form Prepared						

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

Section A: Cardiopulmonary Resuscitation (CPR)

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

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

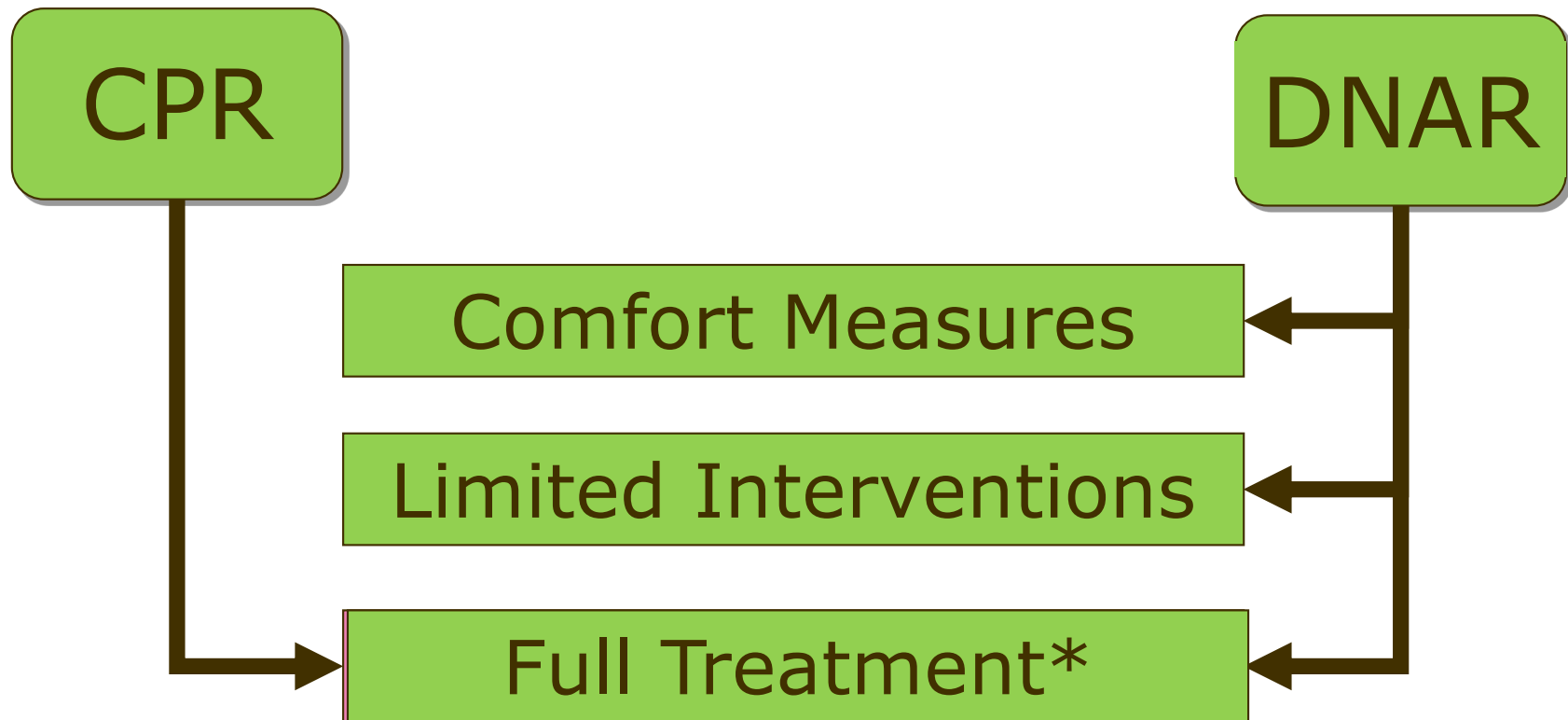
Section B:

Medical Interventions

B Died One	MEDICAL INTERVENTIONS:	** Person has pulse and/or is breathing **
	<input type="checkbox"/> Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Transfer if comfort needs cannot be met in current location.</i>	
	<input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). <i>Transfer to hospital if indicated. Avoid intensive care.</i>	
	<input type="checkbox"/> Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. <i>Transfer to hospital if indicated. Includes intensive care.</i>	
Additional Orders: _____		

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

Diagram of POLST Medical Interventions



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

Section C: Artificially Administered Nutrition

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

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

POLST

Section D – Important Signatures!

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

D Check One	SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:		
	<input type="checkbox"/> Patient or <input type="checkbox"/> Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below:		
	<input type="checkbox"/> Guardian	<input type="checkbox"/> Agent designated in Power of Attorney for Healthcare	<input type="checkbox"/> Patient-designated surrogate
	<input type="checkbox"/> Surrogate selected by consensus of interested persons (Sign section E)		<input type="checkbox"/> Parent of a Minor
	Signature of Provider (Physician/APRN licensed in the state of Hawai'i.) My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.		
	Print Provider Name		Provider Phone Number Date
	Provider Signature (required)		Provider License #
	Signature of Patient or Legally Authorized Representative My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.		
	Signature (required)		Name (print) Relationship (write "self" if patient)
	Summary of Medical Condition		Official Use Only
SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED			

Surrogate: Designated or Non-Designated

Under the Uniform Health Care Decisions Act (Chapter 327E) there are 2 types of surrogate:

- **Designated Surrogate** – A patient may designate any individual to act as a surrogate by personally informing the supervising health-care provider.
- **Non-Patient Designated Surrogate** – one who is selected through agreement by all interested persons when the patient did not designate anyone and patient lacks decisional capacity.

Section E: Surrogate Information

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

Practical considerations

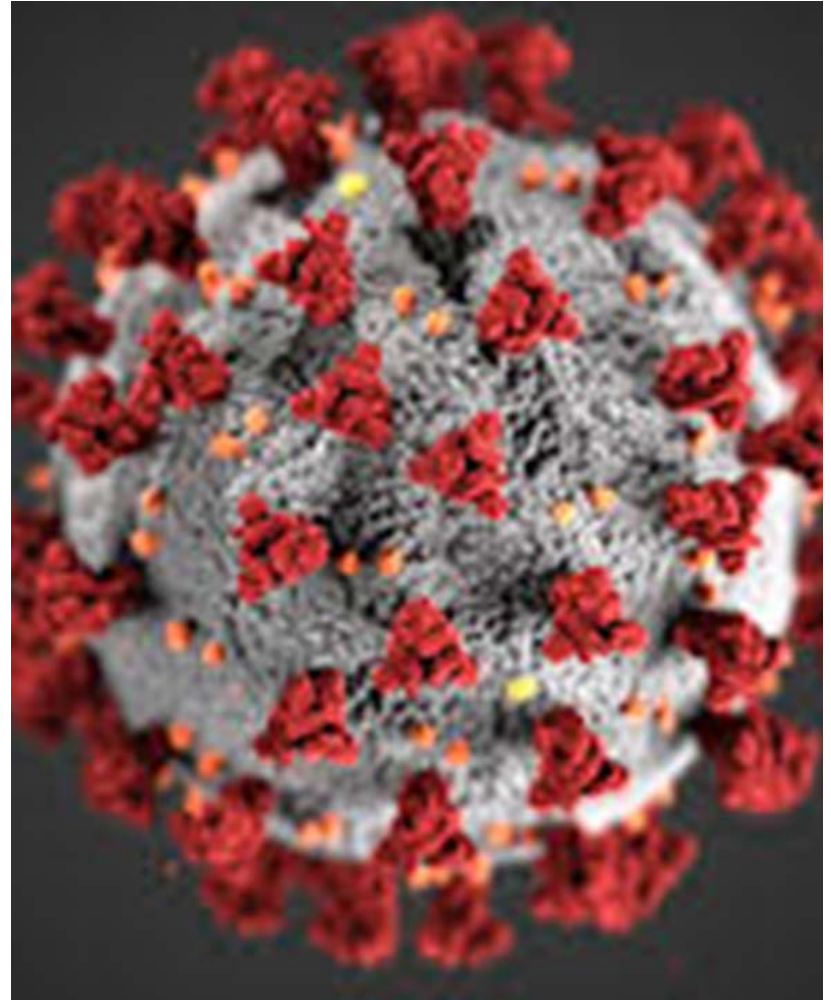
- Recommended to be printed on **lime green** paper (but any color, including black and white is acceptable)
- A copy of the POLST form is legal
- Recommended to be kept in a visible place at home:
 - Refrigerator
 - Bedroom door
 - Bedside table
 - Medicine cabinet
- A copy should be given to EMS personnel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

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?”
- Those who do not want to be taken to the hospital during the pandemic

Considerations surrounding POLST

- Covid19 has changed the way hospitals provide care; visitors are generally not allowed unless patient is dying
- Goals of care conversations can help determine how to best support the individual



Advance Health care Directive vs. POLST

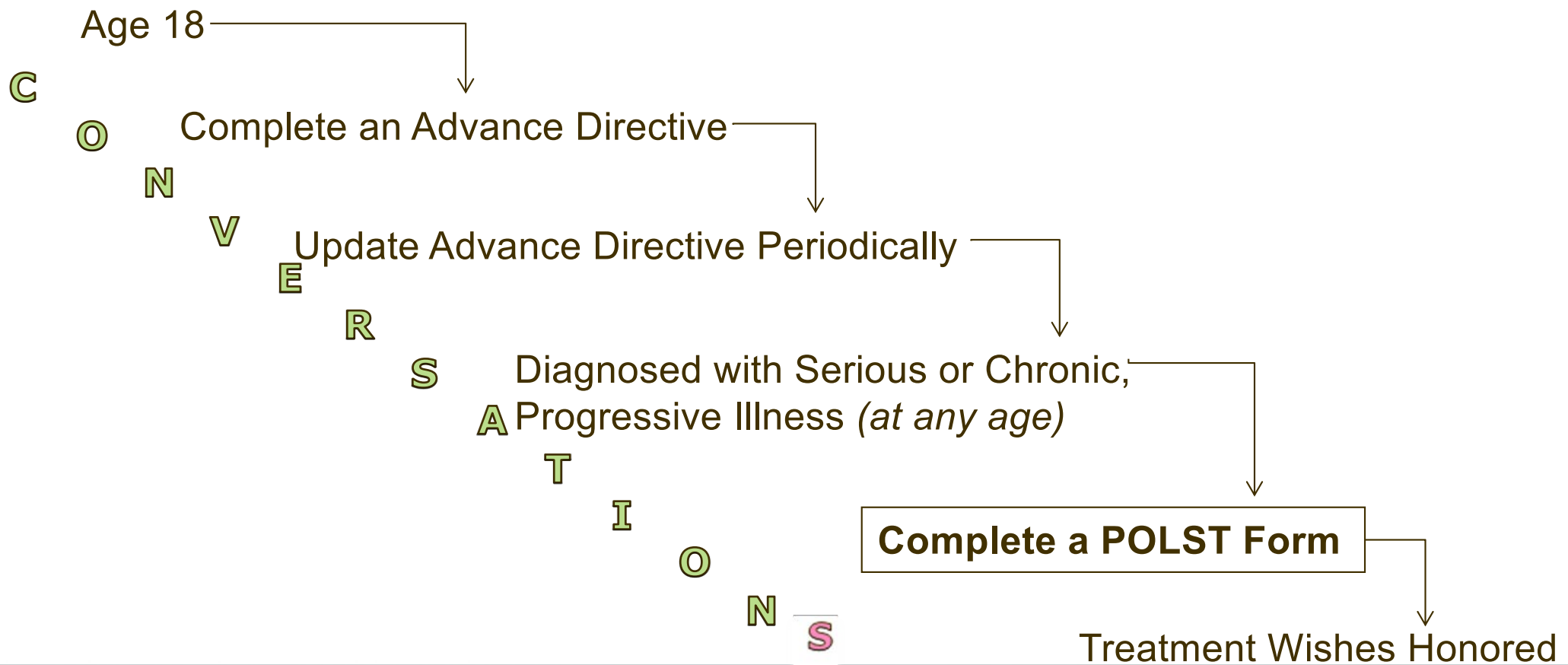
Advance Directives	POLST
For anyone 18 years or older	Persons at any age with serious illness
Identifies wishes for future healthcare	Indicates decisions about current treatments
Appoints a health care representative	Legally authorized representative can be noted
Does not translate into orders for EMS personnel	Actionable orders
CPR/DNR not addressed	CPR/DNR order

Remember...

Everyone needs an
Advance Directive
not everyone needs a
POLST

Where Does POLST Fit In?

Advance Care Planning Continuum



ACP Conversations

- Opportunity to increase awareness of different courses of action possible
- Introduce Palliative Care (HMSA Supportive Care) for individuals with serious illness pursuing curative treatments
- Introduce Hospice for individuals with a terminal diagnosis
- Change the question:
 “What’s the matter with me?”
 to
 “What matters TO me?”

What Is Palliative Care?

- “Palliative care is specialized medical care for people living with a serious illness.
 - This type of care is focused on providing relief from the symptoms and stress of a serious illness.
 - The goal is to improve quality of life for both the patient and the family.
- Palliative care is provided by a specially trained team of doctors, nurses and other specialists who work together with a patient’s other doctors to provide an extra layer of support.
 - Palliative care is based on the needs of the patient, not on the patient’s prognosis.
 - This care is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.”

– Defined by the Center to Advance Palliative Care (CAPC)

Palliative Care-Supportive Care benefit

- Includes, but is not limited to pain management
- In Hawaii, services are often provided by Hospice providers, but is not hospice care.
- Individuals using Palliative care can continue with curative treatment.

Hospice Referrals

- Hospice should be introduced as early as possible when diagnosed with a terminal illness to provide an extra layer of support for individuals and their loved ones.
- Hospice is a team-approach; a physician, a nurse, a social worker, an aide, and a spiritual advisor all assigned to the individual.

State Hospice Providers

<https://kokuamau.org/hospice-providers/>

RESOURCES YOU CAN USE: Hospice Care

Hawai'i:	Hawai'i Care Choices	808-969-1733
	Hospice of Kona	808-324-7700
	North Hawaii Hospice	808-885-7547
Kaua'i:	Kaua'i Hospice	808-245-7277
Maui:	Hospice Maui	808-244-5555
	Islands Hospice Home, Kahului	808-856-8989
Lana'i:	Hospice Hawai'i-Lana'i	808-565-6777
Moloka'i:	Hospice Hawai'i-Moloka'i	808-553-4310
O'ahu:	Bristol Hospice	808-536-8012
	Hospice Hawai'i	808-924-9255
	Islands Hospice	808-550-2552
	Malama Ola Health Services	808-543-1188
	St. Francis Hospice	808-547-6500
	Veterans Administration	808-433-7676

Hospital-based (Inpatient) Palliative Care Programs

Castle Medical Center	808-263-5253
Kaiser Permanente	808-432-7100
Kapi'olani Medical Center for Women & Children	808-983-6090
Maui Memorial Medical Ctr, Palliative Care Coordinator	808-442-5801
North Hawaii Community Hospital	808-885-4444
Pali Momi Medical Center	808-485-4545
Straub Hospital and Clinic	808-522-4000
The Queen's Health System	808-691-4726
Wilcox Memorial Hospital	808-245-1523

Community-Based (Outpatient) Palliative Care Programs

HMSA Case Management Program	1-844-378-9997	808-948-5377
Kaiser Permanente		808-432-8046
Kupu Care by Hawaii Care Choices (Hilo)		808-934-2913
Kōkua Kalihi Valley Home-Based Palliative Care Services		808-791-9410
Palliative Medicine Partners, (Kaua'i)		808-245-7277
St. Francis Supportive Care (O'ahu)		808-595-7566
UHA Comfort Care	800-458-4600 #300	808-532-4006


Join Us at Kōkua Mau!!

Resources and other activities

- Join Kōkua Mau Mailing List
- Download materials from the Kōkua Mau Website – look for the Tool Kit
- Use the new translations
- Request a speaker from Kōkua Mau's **Let's Talk Story** Program – We are ready to talk with your church or other group!

Kokua Mau Resources

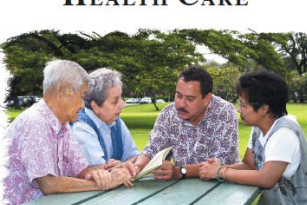
A GUIDE TO ADVANCE CARE PLANNING: MAKING LIFE DECISIONS



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

Executive Office on Aging
Department of Health

YOUR ADVANCE DIRECTIVE FOR FUTURE HEALTH CARE



It is your gift to loved ones, family members and friends so that they won't have to guess what you want if you no longer can speak for yourself

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

Executive Office on Aging
Department of Health

HAWAII ADVANCE HEALTH CARE DIRECTIVE

My name is: Last First Middle Initial Date of Birth (Month/Day/Year)

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

Name	Relationship of individual designated as health care agent	Street Address	City	State	Zip
_____	_____	_____	_____	_____	_____

Time Place 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	Relationship of individual designated as health care agent	Street Address	City	State	Zip
_____	_____	_____	_____	_____	_____

Time Place Cell Phone E-mail

AGENTS' 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 we have no decision, 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 any agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

WHEN AGENTS' 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.

☐ 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 which you do not agree. Initials and date are required.)

A. END OF LIFE DECISIONS

- I have an incurable and irreversible condition that will result in my death within a relatively short time. OR
- I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability. OR
- I have 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.

☐ 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

Questions about CPR

Being asked to make a decision about cardiopulmonary resuscitation (CPR) can be complicated. Few of us have ever seen CPR performed. Our understanding of CPR may come from what we see on TV, where it looks easy and seems to be very successful without any complications. Unfortunately, these TV images of CPR are not completely accurate.

This brochure provides answers to some common questions about what CPR involves and what else is important to think about when making a decision about CPR.

Kokua Mau - Hawai'i Hospice and Palliative Care Organization

WHAT DOES CPR LOOK LIKE?
CPR is a longer process than most people realize. It is an attempt to restart the heart when the heart has stopped beating.

The person is placed on a hard board or on the ground and the center of the chest is pushed in about 1.5 to 2 inches. These chest compressions must be done 100 times each minute. Artificial respiration using a special mask and bag over the person's mouth to pump air into the lungs may be started. When the emergency team arrives, a breathing tube may be inserted into the windpipe to provide oxygen, and a number of electrical shocks may be given with paddles that are placed on the chest. An intravenous line (IV) will be placed in a vein and medications will be given through the IV line.

If the heart continues to respond to these treatments, the person is taken to the emergency department. Those who survive will then be transferred to the intensive care unit at the hospital and attached to a ventilator (breathing machine) and a heart monitor. At this stage, most persons are still unconscious.

WHO IS LEAST LIKELY TO BENEFIT FROM CPR?
Risk factors that are more frequent among older persons may contribute to lower chances of CPR survival as age increases. Most older adults do not have the type of heart rhythm that responds to CPR. Having any chronic disease that affects the heart, lung, brain or kidneys can lower chances for survival after cardiac arrest. If a person has multiple advanced chronic illnesses, CPR survival will be even lower.

Individuals in advanced stages of dementia have CPR survival rates three times lower than those without dementia. Several studies that looked at survival of frail nursing home residents in advanced stages of illness who were dependent on others for all of their care showed CPR survival rates of 0-5% even if they were transferred from the nursing home to the hospital before the cardiac arrest. Older adults in terminal stages of cancer had CPR survival rates 0-1%.

continued on next page

A GUIDE FOR DECISION MAKING

Tube Feeding

"I've been asked to decide about a feeding tube."

Making a decision about a long-term feeding tube for yourself or for someone you love may be challenging and emotional. Those who have faced a similar decision have told us that having honest answers to their questions was most helpful.

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

Kokua Mau - Hawai'i Hospice and Palliative Care Organization

What is a feeding tube?
Artificial nutrition and hydration is a way of giving liquid and nutrients to people who cannot eat or drink by mouth. Usually, for short-term artificial nutrition and hydration, a lengthy tube (called a nasogastric, or "NG" tube) is put through the person's nose and liquid food is put into the stomach. For long-term artificial nutrition and hydration, a tube may be put directly through the abdomen into the stomach, called a gastric, or "G" tube or PEG tube (percutaneous Endoscopic Gastrostomy) or the intestines (called a jejunum or "J" tube). Sometimes fluids are given through a vein (IV).

When are feeding tubes able to help or not?
When individuals lose their ability to swallow or lose interest in eating, this often represents progression of their disease. When this happens, the body is in a natural progression toward the end of life. This normal tendency for the body not to want to eat or drink helps the body to produce its own chemicals (called endorphins) to make itself more comfortable. Sometimes an elderly individual who has not been diagnosed with a disease still begins to lose interest in eating. If the person does not seem to be depressed and there is no other physical cause, this may be a natural process sometimes referred to as "Adult Failure to Thrive".

Who is helped most by having a feeding tube?
Those who function independently but are receiving chemotherapy or radiation for certain cancers and some stroke survivors in rehabilitation whose swallowing ability is expected to return may benefit from temporary feeding tubes.

Will my loved one starve?
Some people fear that not providing a feeding tube means they are letting their loved one "starve to death." This is not true. Starvation occurs when a person whose body needs and can use the nutrients is deprived of food. When a person's body begins to shut down, they may be physically unable to adequately use nutrients that tube feeding would provide, and the chance for bloating and discomfort increases.

continued on next page

A GUIDE FOR DECISION MAKING

HAWAII 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 requires no treatment for that section. Everyone shall be treated with dignity and respect.)

Person's Last Name: _____ Date of Birth: _____ Date Form Prepared: _____

A. CARDIOPULMONARY RESUSCITATION (CPR): **"Person has no pulse and is not breathing"**

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

B. MEDICAL INTERVENTIONS: **"Person has pulse and/or is breathing"**

☐ Comfort Measures Only (Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and initial treatment of urinary 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 low pressure 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 antibiotics/anticoagulation as indicated. Transfer to hospital if indicated. Includes intensive care.)

Additional Orders: _____

C. ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquid by mouth if feasible (See Directions on next page for information on tubes and nutrition)

☐ No artificial nutrition by tube ☐ Definite time period of artificial nutrition by tube

☐ Long-term artificial nutrition by tube ☐ _____

Additional Orders: _____

D. SIGNATURES AND SUMMARY OF MEDICAL CONDITION: Discussed with: ☐ Patient or ☐ Legally Authorized Representative (LAR). LAR is chosen. 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 Hawaii:
My signature below indicates that these orders/instructions are consistent with my wishes or (if signed by LAR) the wishes/wishes of the best interest of the patient who is the subject of this form.

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/instructions are consistent with my wishes or (if signed by LAR) the wishes/wishes of the best interest of the patient who is the subject of this form.

Print Patient Name: _____ Print Date: _____ Relationship (write "self" if patient)

Summary of Medical Condition: _____ (Printed text only)

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

A Provider's Guide to POLST

(Provider Orders for Life-Sustaining Treatment) Maintained for Hawai'i by Kōkua Mau

What is POLST?

POLST (Provider Orders for Life-Sustaining Treatment) is a medical order that gives patients more control over their end-of-life care. It specifies the types of treatments that a patient wishes to receive towards the end of life. Completing a POLST form encourages communication between healthcare providers and patients, enabling patients to make more informed decisions. The POLST form documents those decisions in a clear manner and can be quickly understood by all providers, including first responders and emergency medical services (EMS) personnel. As a result, the patient's wishes can be honored across all settings of care.

Is the POLST simply a DNR order?
NO. POLST is a document that empowers a patient or their legally authorized representative (see below) to make decisions along the whole continuum of care, from very aggressive, life-sustaining care, to comfort care only, to allowing choices about full resuscitation or not at all.

Is POLST the same as an Advance Health Care Directive?
NO. POLST does not replace an Advance Health Care Directive (AHCD). The AHCD can provide significantly more detail about an individual's wishes and preferences for treatment. In addition, the AHCD is the most common mechanism for designating a legally authorized representative decision maker for the patient.

Will the CO-DNR Bracket still be honored by EMS?
YES, the CO-DNR Bracket is still a valid method to communicate a person's intent about attempts to resuscitate. There are still thousands of these brackets in use, and EMS personnel will continue to honor this directive.

Why is the POLST form green?
The POLST form is usually completed on a distinctive bright green form, but is also freely available from the internet (at www.kokuumau.org/polst/) and is acceptable in black and white. The bright color is to make the form highly visible to families and emergency medical services personnel. The lime-green color is also easily copied. A copy on white paper is a valid document.

Does the POLST form travel with the patient between settings of care?
Yes, the POLST form is designed to be a standard form that may be accepted by all providers across the state. As a legal medical order, it will be honored by EMS, hospitals, long-term care facilities, home care and hospice providers may also voluntarily honor the form and include it into their medical records. However, providers with electronic medical records may choose to adapt the essence of the orders into their specific system. Hospital discharge planners are encouraged to support the completion of the POLST form (when clinically appropriate) as a part of their daily practice.

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

How do providers get more copies of the POLST form?
The form is available on the Kōkua Mau web site (www.kokuumau.org/polst/) in PDF format for easy replication. It is the standard that the form be on an 8.5" x 11" sheet of lime colored paper. The form must have both sides copied on the front and back of the paper.

Where is the family encouraged to keep the form?
For the patient's home, the POLST form should be kept in a place readily accessible to family members. Examples include on the refrigerator, in the medicine cabinet, on the back of a bedroom door or on a bedside table. It should be kept with the AHCD.

Page 1 of 3 - A Provider's Guide to POLST - Provided by Kōkua Mau on July 2014 at www.kokuumau.org/forhealthcare/

What is POLST?

Provider Orders for Life-Sustaining Treatment
A Consumer Guide to POLST
Maintained for Hawai'i by Kōkua Mau

• POLST = Provider Orders for Life-Sustaining Treatment: is your care wishes carried out through:

- Your medical orders, completed by a doctor or an Advanced Practice Registered Nurse (APRN).
- Is followed by health care providers, including Emergency Medical Services, such as Paramedics.

• You use POLST when you have a serious health condition.

- Social workers, nurses and other healthcare professionals can help you fill out your own POLST form, but it MUST be signed by your physician or APRN or order to be valid.
- POLST contains medical orders indicating what medical care you want or don't want if you become unable to make the decisions yourself.
- Your doctor or APRN, who is licensed in the State of Hawai'i (or allowed to practice if from the Military or VA) MUST review and sign the POLST form.
- POLST also requires your signature or that of your legally authorized Representative (see page 2 for definition).

When would I need a POLST form?

- The POLST form is intended for a person who has a chronic debilitating illness or is facing a life limiting disease, such as end-stage lung or heart disease or a terminal cancer.
- The decision to create a POLST should be discussed with each person's own provider.

The POLST form asks for information about your preferences for medical treatments:

- Whether to attempt cardiopulmonary resuscitation or not (see website for "Questions about CPR").
- The intensity of medical care you want.
- If you want to be hospitalized and under what conditions, and
- If you want artificial nutrition by feeding tube (see Kōkua Mau website for "Tube Feeding" handout)

FREQUENTLY ASKED QUESTIONS (FAQ)

How do I get a copy of the POLST form?
You or your provider can download a POLST form and instructions for your doctor at the Kōkua Mau website: www.kokuumau.org/polst/. The Kōkua Mau website is the central source for POLST information for Hawai'i. Most hospitals, nursing homes, home health and hospice providers may be required to assist you in the community also have the form for you, and can provide some assistance in understanding it and filling it out. Please remember that your POLST form must be signed by your doctor or Advanced Practice Registered Nurse (APRN) to be valid.

Does the law require that I complete a POLST?
No. POLST is voluntary and has been available in Hawai'i since July 2009. However without a POLST, Emergency Medical Services (EMS) or other healthcare providers may be required to attempt to restart your heart and breathing should they stop, even if you do not wish an attempt to be made to resuscitate you, and would prefer to die a natural death.

Where is the POLST form kept?
If you live at home you should keep the original lime green POLST form in a location where it can easily be seen. The ideal place is in your refrigerator where EMS personnel will look for it first. Other visible places could be the back of the bedroom door, on a bedside table, or in your medicine cabinet. If you reside in a long-term facility, your POLST form may be kept in your medical chart along with other medical orders. A copy of your POLST form on white paper is legal.

Page 1 of 3 - A Consumer Guide to POLST - Provided by Kōkua Mau on July 2014 at www.kokuumau.org/polst/

Since June 2016 the **Hawai'i 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 Hawai'i
- Korean** POLST Form for Hawai'i
- Marshallese** POLST Form for Hawai'i
- Spanish** POLST Form for Hawai'i
- Tagalog** POLST Form for Hawai'i
- Tongan** POLST Form for Hawai'i
- Vietnamese** POLST Form for Hawai'i

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The words "Thank You!" are written in a large, red, cursive script. The text is slanted upwards from left to right, giving it a sense of movement and energy. The letters are thick and have a slight shadow, making them stand out against the white background.



CATHOLIC CHARITIES
HAWAI'I
CIRCLE OF CARE FOR DEMENTIA

Dementia and Dysphagia



Dorothy Arriola Colby
Hale Ku'ike
Director of Community Engagement
Positive Approach to Care Trainer

Dysphagia & Dementia



- Experiencing any issues with swallowing is known as dysphagia.
- The condition can be caused by several factors, including damage to parts of the brain that control swallowing.
- It can be an acute onset (from a stroke, for example) or progressive, as is the case for those living with dementia.
- 9 out of 10 people with dementia will experience dysphagia at some point





Symptoms of Dysphagia

- Drooling saliva, food or fluid
- Effortful or prolonged chewing
- Pocketing of food in cheeks
- Pooling of fluid in mouth
- Spitting out food
- Nasal regurgitation
- Coughing when drinking or eating
- Wet or gurgly voice
- Food getting stuck in the throat or neck region
- Pain or discomfort with swallowing
- Unexplained weight loss
- Chest infections or aspiration pneumonias.

Care Strategies for Dysphagia



- Get a speech pathologist assessment and recommendations on
 - Food and liquid consistencies
 - Positioning
- Create a familiar and forgiving dining environment
- Make food visually appealing
- Watch “Adam’s apple” make sure they have actually swallowed
- Alternate between food and liquid to help clear any residue in mouth
- If you see signs of not swallowing, stop and take a step back and reassess safety of eating.
- Offer food and drink, but do not force.



Final message related to dysphagia and dementia

With dementia, it is about our relationship
NOT about getting it in & getting it done

Learn More About Dysphagia (swallowing difficulties) and Aging



<https://geriatrics.jabsom.hawaii.edu/resources/>

This video is available in English, Samoan, Ilocano and Chuukese!

Winter 2020 Zoom Workshop Series

**Geriatrician Perspectives on Dementia, Caregiving, and Brain Health
for Caregivers of Persons Living with Memory Loss**

• Presented by Dr. Kamal Masaki and Dr. Aida Wen

<https://bit.ly/CCH2020DementiaWorkshops>

Healthy Brain Aging and Dementia

• Nov 18 • 10:30-noon (*note later start time*)

Non-Medication Strategies for Dementia Behaviors

• Nov 24 • 10:00-11:30 am

Principles of Medication Use in Older People

• Dec 3 • 10:00-11:30 am

The 3 D's: Dementia, Delirium and Depression: Knowing the Difference

• Dec 10 • 10:00-11:30 am

Thank you!

Thank you so much for your desire to learn and your commitment to making a positive difference!

Please also help us support this grant by completing a short anonymous demographic and quality survey after this webinar. Your feedback is important to us, and helps us to keep providing these free educational events to our community.

To learn more about the Hawaii Circle of Care for Dementia visit, www.catholiccharitieshawaii.org/dementia/

To learn more about Kokua Mau visit www.kokuamau.org

Please help us support this grant by completing this short 5-question post-test poll. All answers are anonymous.

Thank you for your participation!

