

Kōkua Mau's Let's Talk Story Program

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Advance Care Planning Coordinator

Navigating Serious Illness and End-of-Life Options
Behavioral ECHO



Who is *Kokua Mau*?

- ▶ 501(c)3, community benefit org., statewide (not a state agency)
- ▶ Membership - hospices, health plans, hospitals, long term care, spiritual care, EOA, Maui County Office on Aging
- ▶ 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

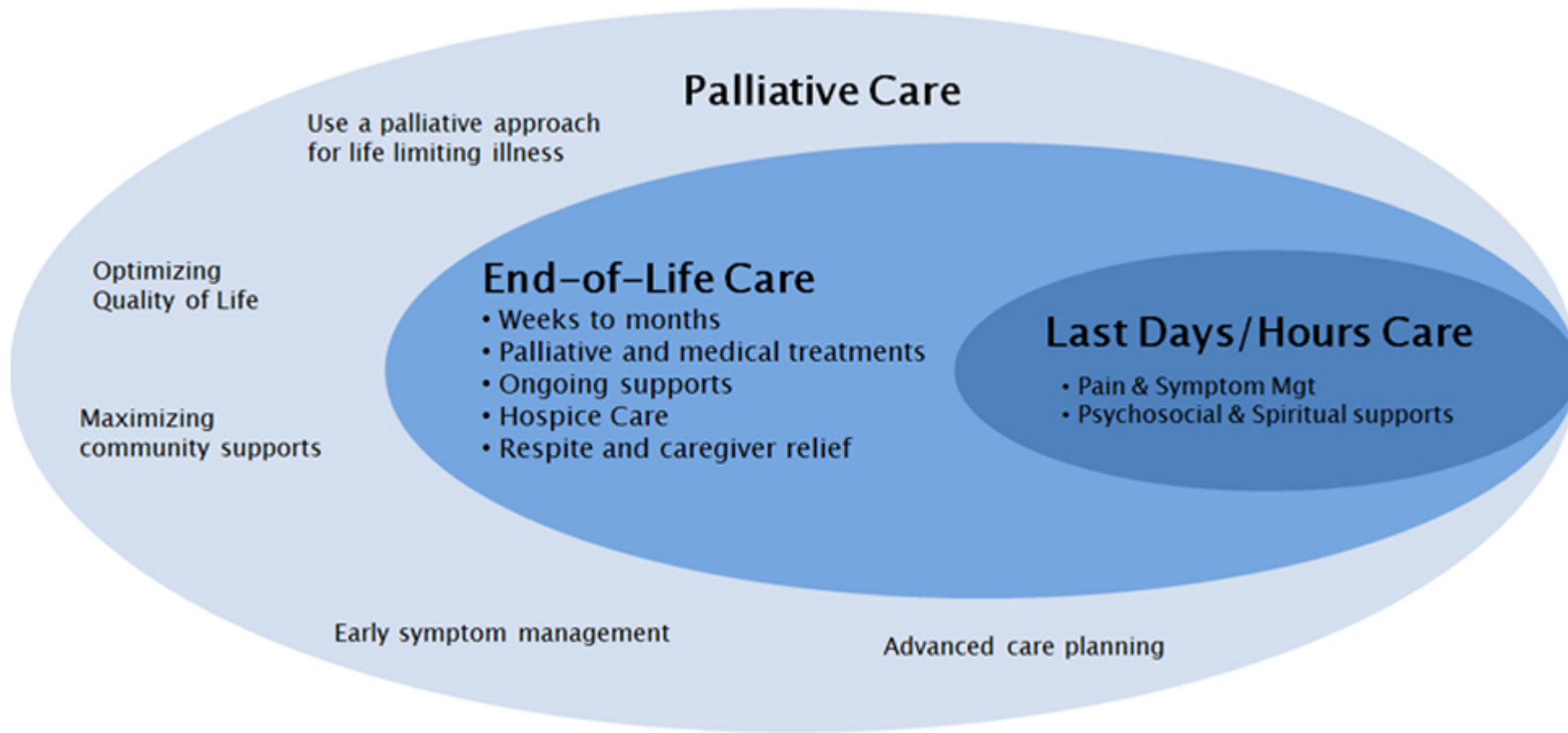
“...modern medicine has yet to make even one person immortal. Therefore, at some point, more treatment does not equal better care.”

--Dr. Ira Byock

A Movement for Change

Kokua 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*





End-of-life care is hospice care

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

- ▶ To palliate is to “ease the symptoms without curing the underlying condition” Merriam-Webster
- ▶ Often is confused with hospice
- ▶ Hospice care is a type of Palliative care, but Palliative care is not a type of hospice.

Signs that Palliative Care is needed

- ▶ Frequent ER visits or calls to the doctor
- ▶ Difficulty managing medications
- ▶ Diminished activities of daily living i.e. managing finances, driving, grocery shopping, preparing meals, light housekeeping
- ▶ Pain, fatigue, swelling in feet & legs, nausea

When should Palliative Care begin?

- ▶ At the time of diagnosis
- ▶ Throughout the course of the illness
- ▶ Those with medical issues could live longer, and have a better quality of life by accessing palliative care early

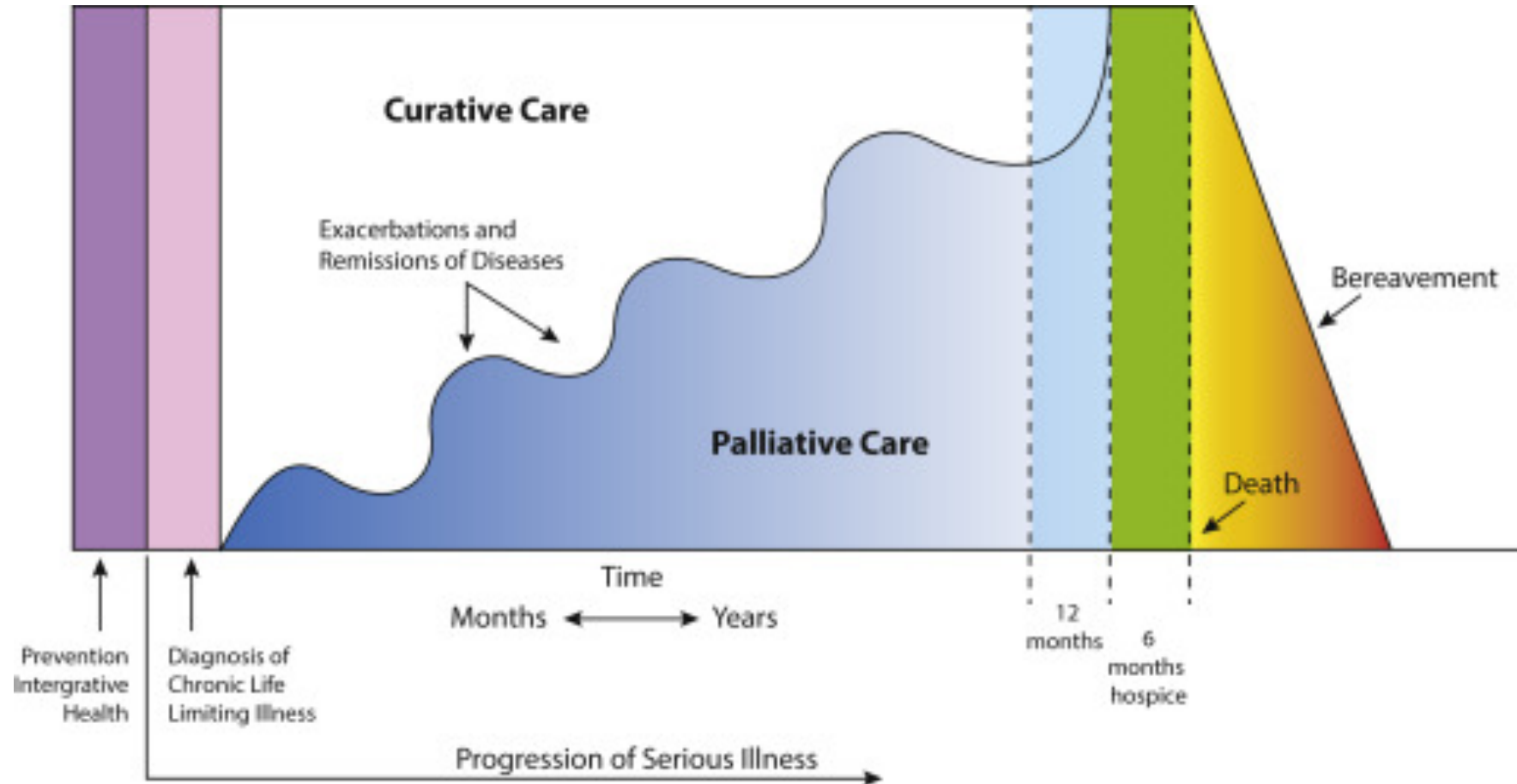
Why Palliative Care?

- ▶ Early, upstream interventions to live well with your illness
- ▶ Focuses 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
- ▶ Provides an extra layer of support

Why Palliative Care -con't

- ▶ Provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient's other providers
- ▶ It is appropriate at any age and at any stage in a serious illness
- ▶ Can be provided along with curative treatment

Use of palliative care throughout serious illness and frail health



Where can you find Palliative Care?

1. In-patient

2. Out-patient - QMC Supportive Oncology Clinic

3. In-home

- ▶ HMSA: Supportive Care
- ▶ UHA: Concurrent Care
- ▶ VA: Supportive Care Benefit (only available in Hawaii)
- ▶ Hawaii Care Choices (Hilo): Kupu Care
- ▶ Kauai Hospice
- ▶ Bristol Hospice on Oahu (new program)
- ▶ Attention Plus Home Health
- ▶ Navian Hawaii
- ▶ Islands Supportive Services

Myths and Facts about Palliative Care

Myth:

- ▶ Palliative care is only for pain management
- ▶ Palliative care is the same as hospice
- ▶ Palliative care is only for cancer patients
- ▶ Palliative care means stopping all treatments

Fact:

- ▶ Pain management is part of palliative care, which is a philosophy of care with an interdisciplinary approach during a serious illness
- ▶ In palliative care, individuals can continue with **curative** treatment, and is not necessarily end-of-life care
- ▶ Palliative care is for anyone facing a serious illness and is not based on diagnosis or prognosis
- ▶ Palliative care is an additional layer of support while receiving curative treatments

Poll and check in

- ▶ Before this session:
- ▶ True or False
- ▶ Any questions about Palliative Care?

End-of-life options: Hospice

“The way we die lives on in the memory of those who survive”

--Dame Cicely Saunders,
founder of the modern hospice movement

Preliminary poll on Hospice

- ▶ When do we call hospice?
- ▶ Where do you get hospice?

Hospice Care

- ▶ Specialized type of care for those facing a life-limiting illness, their families and their caregivers. Individuals with a diagnosis of 6 months or less to live.
- ▶ Addresses the patient's physical, emotional, social and spiritual needs.
- ▶ Helps the patient's family, loved ones and caregivers
- ▶ Takes place in the patient's home or in a home-like setting.

Hospice Care - con't

- ▶ Concentrates on managing a patient's pain and other symptoms so that the patient may live as comfortable as possible and make the most of the time that remains.
- ▶ Believes the quality of life to be as important as length of life
- ▶ Available on all islands
- ▶ Hospice care allows a natural death without unwanted interventions while providing support to the individual and loved ones at the end-of-life

Why Hospice?

- ▶ Hospice offers patient-centered care in a team approach; Physician, Nurse, Social Worker, Aide, Spiritual Advisor for each hospice patient including bereavement support for loved ones
- ▶ Hospice allows individuals to avoid unwanted ER visits and hospital stays
- ▶ Hospice supports loved ones after death

The Cool Kids Club



When is it time for Hospice Care?

- ▶ Multiple visits to the ER or the Doctor
- ▶ Weight loss, increase in falls
- ▶ Difficulty getting out of bed or a chair
- ▶ Sleeps most of the time, unable to stay awake
- ▶ Recurrent infections and skin breakdowns
- ▶ Decision to stop any curative treatments

Change the focus:

“What’s the matter with me?”

TO:

“What matters to me...”

Thoughtful reflection:

- ▶ If faced with a terminal and life-limiting illness, how would I want to spend the rest of my time? Where would I want to be?
- ▶ Hospice will focus on quality of life, rather than quantity of life. What does quality look like for you?



When curative treatments aren't effective and precious time could be doing and/or being with someone else, what would you choose?

Hospice will focus on quality rather than quantity. What does quality look like for you?



13 Facts (not Myths) about Hospice

1. Hospice is not a place - people receive services where they live.
2. Loved ones and relatives are part of the team caring for the hospice patient. They are supported by the hospice team.
3. Hospice is not a last resort. When cure is no longer possible, hospice can do many things to control pain, reduce anxiety, offer spiritual and emotional support, and improve quality of life for terminally ill people and their families.

Facts about Hospice (con't)

4. Hospice has no religious affiliation.

- Chaplains and other spiritual counselors come from all faiths and no faith.
- Respect all cultures and points of view.
- Lend support and discuss the patient's and the family's feelings.

5. Hospice is not just for cancer patients but for anyone with a terminal illness.

Facts about Hospice (con't)

6. Hospice care is not expensive.
7. Hospice does not forego medications or treatments but uses state-of-the-art medications & palliative treatments to relieve pain and symptoms to keep patients comfortable.
8. Hospice does not mean anyone has failed the patient.
9. Hospice is not about giving up; it's about living in comfort and dignity for the time one has left.
10. Hospice is about living well up until the time of death

Facts about Hospice (con't)

11. Hospice does not make death come sooner, it can actually make people live longer!
12. Morphine prescribed to a hospice patient does not cause premature death but helps maintain Quality of life until the end of life
13. Hospice is **NOT** euthanasia or physician assisted suicide - the dying process is not speeded up.

It is possible to live well, even in the face of serious illness

Remember there are many ways to help:

- ▶ Comfort - physically and mentally
- ▶ Connection - spiritually, family, friends, socially
- ▶ Preparation - personally and medically
- ▶ Guidance through a rite of passage

Be proactive with learning treatment options

- ▶ Receiving a diagnosis is difficult. Explore your treatment options and discuss with your provider what matters most to you.
- ▶ If you are asked to complete a POLST (Providers Orders for Life Sustaining Treatment) due to a serious illness, ask for a palliative consult.
- ▶ Have thoughtful and meaningful conversations about your wishes for care with loved ones and complete an Advance Health Care Directive. Share it with your provider and your loved ones.

Poll and check in

- ▶ When should we call hospice?
- ▶ Where can we get hospice?

Questions about hospice?

Our Care, Our Choice Act (OCOCA)

- ▶ Many terms for Medical Aid in Dying
 - ▶ “Physician Assisted Suicide”
 - ▶ “Medically assisted death”
 - ▶ “Euthanasia”, “suicide”
 - ▶ “Medically hastened death”

Language is important to mindful of.

Legal Requirements

- ▶ Took effect January 1, 2019
- ▶ Adult resident of Hawaii with a prognosis of less than six months
- ▶ Mentally capable of making decisions
- ▶ Acting voluntarily
- ▶ Capable of self administering medication

Recommended enrollment in a hospice program

Patient Requests

- ▶ Two oral request separated by no more than 20 days (current legislation could change this)
- ▶ One written request witnessed by two people, at least two days before prescription is written
- ▶ A mental health evaluation
- ▶ One signed final attestation



KŌKUA MAU
Continuous Care
A Movement to Improve Care

Provider Roles

- ▶ **Attending physician** is a licensed physician defined as having "responsibility for the care of the patient and treatment of the patient's terminal illness."
- ▶ **Consulting provider** is a licensed physician "who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease."

Mental Health Counseling

- ▶ Mental health counseling must be provided.
- ▶ Can be Psychiatrist, Psychologist or Licensed Clinical Social Worker.
- ▶ Must confirm person is “capable”
- ▶ Must confirm patient is not suffering from under-treatment or non-treatment of depression or conditions which may interfere with ability to make an informed decision.
- ▶ May be a tele health encounter.



Other provisions

- ▶ Death certificate shall list the terminal disease as the immediate cause of death
- ▶ Unused medication shall be delivered for disposal to the nearest qualified facility
- ▶ No Effect on Life Insurance or Annuity
- ▶ Act does not authorize euthanasia
- ▶ Organizations, facilities, and providers may participate or refuse to participate

Special Consideration

- ▶ Federal prohibition against use of federal monies for any activities associated with “assisted suicide”
- ▶ Still trying to understand this limitation
- ▶ Medicare beneficiaries/federally insured may have to pay out of pocket
- ▶ This should not prevent you from discussing MAID and all options for end of life care
 - ▶ Office visit is covered if linked to chronic condition



Key Points to Remember

- ▶ Attending physician responsible for ensuring all requirements are met
- ▶ Providers who are allowed to complete steps in the process are clearly defined
 - ▶ Not everyone can complete process
- ▶ Participation in the process is completely voluntary
- ▶ Some populations will probably have more difficulty accessing this choice
- ▶ It is an out-of-pocket expense



Key things to remember

- ▶ Individuals who request to use OCOCA, should be enrolled in hospice during the waiting period
- ▶ If OCOCA is being considered, it is recommended to start the process early
- ▶ There are limited providers who are participating
- ▶ Providers and health systems are not required to participate

Current legislation could change rules

- ▶ Potentially changing the timeline to reduce the waiting period
- ▶ Potentially changing the requirements to include Nurse Practitioners to be prescribers
- ▶ Potentially changing rules to make exceptions for people very close to death

Reasons for Requesting MAID

Patient Concern	Oregon	Washington
Loss of Autonomy	91.6%	86%
Less able to engage in enjoyable activities	89.7%	86%
Loss of Dignity	78.7%	69%
Losing control of bodily functions	48.2%	49%
Burden on family/friends/caregivers	41.1%	52%
Inadequate pain control or fear of it	25.2%	35%
Financial implications of treatment	3.1%	13%

For More Information & Forms

State of Hawaii Department of Health

▶ health.hawaii.gov/opppd/ococ/

Kōkua Mau

▶ kokuamau.org

California Coalition for Compassionate Care

▶ <https://coalitionccc.org/>

Join Us at Kokua Mau!!

Resources and other activities

- ▶ Join Kokua Mau Mailing List
- ▶ Download materials from the Kokua Website - look for the Tool Kit
- ▶ Use the new translations
- ▶ Request a speaker from Kokua 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

KOKUA MAU
"Continuous Care"
Hawaii's Hospice and Palliative Care Organization

Executive Office on Aging
Department of Health

YOUR ADVANCE DIRECTIVE FOR FUTURE HEALTH CARE

HAWAII ADVANCE HEALTH CARE DIRECTIVE

My name is: _____ Form: Middle-Initial _____ Date of Birth: _____

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 Email

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 Email

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 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 plurality of my preferences are to be ascertained for me by a court, I maintain 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'll mark this box, my agent's authority to make health care decisions for me takes effect immediately. However, I hereby retain the right to make any decisions about my health care that I revoke this authority as 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, 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 life span, I want my agent to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability.
 - If I have not the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability.
 - If I have not the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability.

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 2

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, those 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 re-start 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 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, although tubes 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 they increase. Most older adults do not have the type of heart rhythm that responds to CPR. Having any chronic disease that affects the heart, lungs, 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 0-9% 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 = 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 comfortable eating program 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 nasogastric tube (called a nasogastric "NG" tube) is put through the person's nose and ligated through the skin into the stomach, called a gastric or "G" tube or PEG tube (Percutaneous Endoscopic Gastrostomy) or the stoma (called a stoma or "T" tube). Sometimes fluids are given through a vein (IV).

When are feeding tubes best used?

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 are physically unable to adequately use nutrients that tube feeding would provide, and the chance for bleeding and discomfort increases.

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 are physically unable to adequately use nutrients that tube feeding would provide, and the chance for bleeding and discomfort increases.

A GUIDE FOR DECISION MAKING

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

PLEASE follow these orders. They control the patient's preferences. They are based on the patient's current medical condition and wishes. They may not completely resolve all treatment for that condition. Treatment that is necessary with dignity and respect.

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing Attempt Resuscitation/CPR Do Not Attempt Resuscitation/DNAR (Also: No-CPR) Decision B: Full Treatment required

B MEDICAL INTERVENTIONS: Person has pulse and/or is breathing Comfort Measures Only. Use medications 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. Respite if comfort needs cannot be met in current location. Limited Additional Interventions include care described above, the medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. Use tube as indicated or only support if continued to prevent positive airway pressure. Transfer to hospital if indicated. Avoid restraints. Full Treatment. Include care described above, the medication, advanced airway interventions, mechanical ventilation and other interventions as indicated. Permitted by Hawaii Practitioner, including Intensive Care.

C ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquid by mouth if feasible

No artificial nutrition by tube Comfort end period of artificial nutrition by tube Long term artificial nutrition by tube

D SIGNATURES AND SUMMARY OF MEDICAL CONDITION (Discussed with patient or legally Authorized Representative (LAR))

Patient or Legally Authorized Representative (LAR) (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 designation of interested persons (sign section 3) Parent of a Minor

Signature of Provider (Physician/ARNP licensed in the state of Hawaii)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Provider Signature (Printed) _____ Provider License # _____
Signature of Patient or Legally Authorized Representative
My signature below indicates that I have read and understand these orders and I agree to sign the POLST form and to be the responsible party for the completion of this form.

Signature (Printed) _____ Relationship (Printed) (Self if patient)
Signature (Printed) _____ Relationship (Printed) (Self if patient)

Summary of Medical Condition _____ Date/Time Only _____

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

A Provider's Guide to POLST

Provider Orders for Life-Sustaining Treatment Maintained for Hawaii by Kokua 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, including choice about full resuscitation or do not attempt resuscitation.

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

Why is the POLST form lime green?
The POLST form is usually completed on a distinctive bright lime-green form, but is also freely available from the internet (at www.kokuamau.org/polst) and is acceptable in black and white. The bright color is to make the form quickly visible to handlers 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 portable form that may be accepted by 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 keep 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 completing the orders from the POLST form protected under Hawaii Law?
Yes. The law states that no provider or other person shall be held liable for refusing to carry out the treatment orders in good faith or for performing cardiopulmonary resuscitation if the person performing CPR was unaware of the POLST order to not attempt resuscitation or they believed that the treatment orders (including the DNR order) had been revoked or cancelled.

How do providers get more copies of the POLST form?
The form is available on the Kokua Mau web site: www.kokuamau.org/polst in PDF format for easy application. It is also possible that the form be on an EMS or EMT's pocket of line 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 should be kept in a clearly accessible by 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 2 - A Provider's Guide to POLST - Provided by Kokua Mau on July 2014 at www.kokuamau.org/information

What is POLST?

Provider Orders for Life-Sustaining Treatment A Consumer Guide to POLST Maintained for Hawaii by Kokua Mau

POLST - Provider Orders for Life-Sustaining Treatment is your wish carried out through:

- your medical orders, completed by a doctor or an Advanced Practice Registered Nurse (APRN)
- followed by health care providers, including Emergency Medical Services, such as Paramedics.
- 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 nurse 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 Hawaii (or allowed to practice from the military or VA) MUST review and sign the POLST form.
- POLST also requires your signature or that of your legal representative.

Representative (see page 2 for definition).

When would I need a POLST form?

- Whether to attempt cardiopulmonary resuscitation or not (see website for "Questions about CPR").
- 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:

- The intensity of medical care you want.
- If you want to be hospitalized and/or under watch conditions, and
- If you want artificial nutrition by feeding tube (see Kokua 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 Kokua Mau website (www.kokuamau.org/polst). The Kokua Mau website is the central source for POLST information for Hawaii. Most hospitals, nursing homes, home health and hospice providers as well as others in the community also have the form for you, and the provider can assist you 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 a completed POLST form?
NO. POLST is voluntary and has been available in Hawaii 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 best place is on 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 2 - A Consumer Guide to POLST - Provided by Kokua Mau, on July 2014, at www.kokuamau.org

Chinese simplified Hawaii Advance Health Care Directive
Chinese traditional Hawaii Advance Health Care Directive
Ilocano Hawaii Advance Health Care Directive
Japanese Hawaii Advance Health Care Directive
Korean Hawaii Advance Health Care Directive
Marshallese Hawaii Advance Health Care Directive
Spanish Hawaii Advance Health Care Directive
Tagalog Hawaii Advance Health Care Directive
Tongan Hawaii Advance Health Care Directive
Vietnamese Hawaii Advance Health Care Directive

Since June 2016 the **Hawaii POLST Form** is available in **10 languages**:

- Chinese simplified POLST Form for Hawaii
- Chinese traditional POLST Form for Hawaii
- Ilocano POLST Form for Hawaii
- Japanese POLST Form for Hawaii
- Korean POLST Form for Hawaii
- Marshallese POLST Form for Hawaii
- Spanish POLST Form for Hawaii
- Tagalog POLST Form for Hawaii
- Tongan POLST Form for Hawaii
- Vietnamese POLST Form for Hawaii

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www.theconversationproject.org



Thank You!