



POLST

Provider Orders for Life Sustaining Treatment

History:

- National



- Minnesota

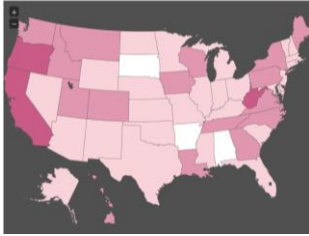


MINNESOTA
MEDICAL
ASSOCIATION



Changes:

- Meet national standards
- National endorsement



Currently:

- 19 Endorsed (3 Mature)
- 25 Developing
- 3 Non-conforming
- 3 Not (yet) developing



MINNESOTA **Provider Orders for Life-Sustaining Treatment (POLST)**

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. Any action not completed does not invalidate the form and implies full treatment for that action. With significant change of condition, new orders may need to be written. Patients should always be treated with dignity and respect.

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____
 DATE OF BIRTH: _____
 PRIMARY MEDICAL CARE PROVIDER NAME: _____ PRIMARY MEDICAL CARE PROVIDER PHONE NUMBER: _____

A CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing.*

CHECK ONE

Attempt Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

Do Not Attempt Resuscitation / DNR (Allow Natural Death).

When not in cardiopulmonary arrest, follow orders in B.

B MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

CHECK ONE (NOTE REQUIREMENTS)

Full Treatment. Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

Selective Treatment. Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.

Comfort-Focused Treatment (Allow Natural Death). Relieve pain and suffering through the use of any medications by any route, positioning, wound care and other measures. For oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

TREATMENT PLAN: Maximize comfort through symptom management.

C DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

Patient (Patient has capacity) Court-Appointed Guardian Other Surrogate

Parent of Minor Health Care Agent Health Care Directive

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE (STRONGLY RECOMMENDED) _____ NAME (PRINT) _____

RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF") _____ PHONE (WITH AREA CODE) _____

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

D SIGNATURE OF PHYSICIAN / APRN / PA

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

NAME (PRINT/REQUIRED) _____ LICENSE TYPE (REQUIRED) _____ PHONE (WITH AREA CODE) _____

SIGNATURE (REQUIRED) _____ DATE (REQUIRED) _____

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. ALSO PHOTOGRAPH OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.

Minnesota Provider Orders for Life-Sustaining Treatment (POLST). www.mpolst.org PAGE 1 OF 2

Newly-revised Minnesota form:

Added our state name on front!



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Newly-revised Minnesota form:

Sections A & B:

Indicate connection between choices made in sections A & B

List options from most treatment to least

Describe in patient-friendly vocabulary

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Newly-revised Minnesota form:

Sections C & D:

Move to front to indicate importance

Clarify signature space

INFORMATION FOR
PATIENT NAMED ON THIS FORM

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

E ADDITIONAL PATIENT PREFERENCES (OPTIONAL)

CHECK ONE FROM EACH SECTION

ARTIFICIALLY ADMINISTERED NUTRITION *Offer food by mouth if feasible.*

- Long-term artificial nutrition by tube.
- Defined trial period of artificial nutrition by tube.
- No artificial nutrition by tube.

ANTIBIOTICS

- Use IV/IM antibiotic treatment.
- Oral antibiotics only (no IV/IM).
- No antibiotics. Use other methods to relieve symptoms when possible.

ADDITIONAL PATIENT PREFERENCES (e.g. dialysis, duration of intubations).

HEALTH CARE PROVIDER WHO PREPARED DOCUMENT

PREPARER NAME (REQUIRED) _____ PREPARER TITLE (REQUIRED) _____
 PREPARER PHONE (WITH AREA CODE) (REQUIRED) _____ DATE PREPARED (REQUIRED) _____

NOTE TO PATIENTS AND SURROGATES

The POLST form is always voluntary and is for persons with advanced illness or frailty. POLST reflects your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. A Health Care Directive is recommended for all capable adults, regardless of their health status. A Health Care Directive allows you to document in detail your future health care instructions and/or name a Health Care Agent to speak for you if you are unable to speak for yourself.

DIRECTIONS FOR HEALTH CARE PROVIDERS

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- POLST should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of a Health Care Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/APPN/PA in accordance with facility/community policy.
- A surrogate may include a court-appointed guardian, Health Care Agent designated in a Health Care Directive, or a person whom the patient's health care provider believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known, such as a verbally designated surrogate, spouse, registered domestic partner, parent of a minor, or closest available relative.

Reviewing POLST

This POLST should be reviewed periodically, and if:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change, or
- The patient's Primary Medical Care Provider changes.

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Show line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.

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Minnesota Provider Orders for Life-Sustaining Treatment (POLST). www.mnpolst.org PAGE 2 OF 2 REVISED: JULY 2016

Newly-revised Minnesota form:

Back (Page 2):

Add patient name on page 2

Allow space for optional treatment indicators

Clarify preparer information

Update and clarify instructions

Add URL and revision date

The **ICPP** Program

Identify patients who you wouldn't be surprised if they died in the next year

Communication between the doctor and the identified patient about their prognosis, goals, and wishes

POLST completion of a POLST to reflect patient wishes

Payment as of January 1, 2016 physicians will be reimbursed by Medicare for these discussions

POLST

Provider Orders for Life Sustaining Treatment

What's next:

- Final approvals and endorsements
- Education development
- Roll out!



Questions?

