COMMUNITY HEALTH PLAN of Washington™

Department:	Health Services	Original Approval:	02/12/2016
Policy #:	HS015	Last Approval:	03/30/2020
Title:	Advance Directives and Physician Orders for Life Sustaining Treatment (POLST) Policy		
Approved By:	CMO Cabinet		
Dependencies:	Advance Directives Procedure (CO291) Advance Directives Procedure (CO292) Advance Directives Policy & Procedure (CS528)		

Purpose

This policy defines the manner in which the Case Managers, Care Coordinators and contracted providers of Community Health Plan of Washington (CHPW) will inform CHPW members of their right to implement Advance Directives and Physician Orders for Life Sustaining Treatment (POLST) documents.

Policy

CHPW Case Managers, Care Coordinators and contracted providers will provide information to enrollees who express an interest in developing and maintaining a Medical and/or Mental Health Advance Directive or a Physician Order for Life-Sustaining Treatment (POLST) document.

As part of the care management process of assessment, care planning, and ongoing care coordination with members, CHPW case management staff will include an evaluation of the member's existing Advance Directives and POLST, if available. If not available, they will inform the member about Advance Directives and inquire about their interest in developing one.

CHPW will provide a copy of the Advance Directives policies and procedures and associated forms upon request by providers, members, and/or the Healthcare Authority representatives.

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Definitions

ADVANCE DIRECTIVE: - An Advanced Directive is a written document in which the principal makes a declaration of instructions or preferences regarding his or her medical and mental health treatment. The principal may also appoint an agent to make these decisions on his or her behalf. If the enrollee wishes to appoint an agent to make decisions for them, a Durable Power of Attorney must be completed.

An advance directive provides written instructions about an enrollee's future medical care in the event that the enrollee is unable to express his or her medical wishes. In the state of Washington, this written instruction is in the form of two documents: A **Health Care Directive** (also known as a Living Will) and a **Durable Power of Attorney for Health Care**.
A **Mental Health Advance Directive** provides instructions and/or appoints an agent to make decisions on behalf of the enrollee if they become incapacitated by mental illness and are unable to communicate effectively.

An Advance Directive places the enrollee's choices for health care into writing and tells the doctor and family what kind of health care they do or do not want if they:

- Have lost consciousness
- Can no longer make health care decisions
- Cannot tell their doctor or family what kind of care they want
- Wish to donate their organ(s) after death
- Want someone else to decide about their healthcare if they cannot

There are three types of Advance Directives in use within Washington State:

1. Durable Power of Attorney for Health Care. This names another person to make medical decisions if the enrollee is not able to make decisions for themselves.
2. Healthcare Directive (living will). This written statement tells people whether the enrollee wants treatment to prolong their life
3. Organ donation request.

If the enrollee wishes to appoint an agent to make decisions for them, a Durable Power of Attorney must be completed. Beginning January 1, 2017, all Durable Power of Attorney for Health Care documents must either be witnessed by two individuals or be notarized. Powers of attorney executed prior to January 1, 2017 will remain valid.

Copies of completed advance directives should be maintained as part of the physician's clinical records.

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AGENT - An Agent is a person to whom authority is given to make decisions on behalf of the enrollee.

ENROLLEE - An Enrollee is an adult who has executed a Medical and/or Mental Health Advance Directive or POLST.

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST): The Physician Orders for Life Sustaining Treatment (POLST) is a form that gives seriously ill patients more control over their end-of-life care, including medical treatment, extraordinary measure (such as a ventilator or feeding tube) and CPR. POLST helps a doctor know what you would like to do when you are seriously ill and in life sustaining treatment.

The enrollee's physician can use the POLST form to represent the enrollee's wishes as clear and specific medical orders. Enrollees should be encouraged to contact their doctor to learn more. Forms are available at the physician's office or by contacting Washington State Medical Association POLST resources.

Copies of completed POLST documents should be maintained as part of the physician's clinical records.

PRINCIPAL - A Principal is any individual who has capacity and who gives another individual the legal authority to act on their behalf.

List of Appendices

Appendix A: Sample of Physician's Order for Life Sustaining Treatment (POLST) Form

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Citations & References

CFR	42 CFR 422.128	
WAC		
RCW	71.32	
Contract Citation	☒ WAH - IMC	10.3 Advance Directives and POLST
	☐ MA	MMCM Ch 4 section 180
Other Requirements	42CFR. 438	
NCQA Elements		

Revision History

Revision Date	Revision Description	Revision Made By
02/12/2016	Original	Melissa Shilipetar
03/22/2017	Approval	MMLT
04/13/2018	Annual update	Darla Bernstein
04/16/2018	Approval	Patty Jones, SVP
04/10/2019	Annual update	Darla Bernstein
04/11/2019	Approval	Patty Jones
02/25/2020	Annual update	Darla Bernstein
03/04/2020	Approval	Ma'ata Hardman
03/30/2020	Approval	CMO Cabinet

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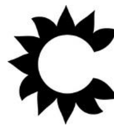

Appendix A: Example of a Physician's Order for Life Sustaining Treatment (POLST) Form

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

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial

Date of Birth ______ Last 4 #SSN (optional) ______

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a POLST form is always voluntary. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

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

Check One

When not in cardiopulmonary arrest, go to part B.

- ☐ **Attempt Resuscitation/CPR**
- ☐ **Do Not Attempt Resuscitation/DNAR (Allow Natural Death)**
  Choosing DNAR will include appropriate comfort measures.

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

Check One

- ☐ **FULL TREATMENT - primary goal [illegible] nging life by all medically effective means.**
  Includes care described below. Use [illegible] nced airway interventions, mechanical ventilation and cardioversion as indicated. **Transfer** *to hospital if [illegible] intensive care.*
- ☐ **SELECTIVE TREATMENT - goal of treat[illegible] ditions while avoiding burdensome measures.**
  Includes care described below. Use medical tre[illegible] and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, Bi[illegible] *hospital if indicated. Avoid intensive care if possible.*
- ☐ **COMFORT-FOCUSED TREATMENT - primary goal of [illegible] g comfort.**
  Relieve pain and suffering with medication by any route as ne[illegible] d. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.*

SAMPLE

Additional Orders: (e.g. dialysis, etc.) ______________________

C — SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with: ☐ Patient ☐ Parent of Minor ☐ Guardian with Health Care Authority ☐ Spouse/Other as authorized by RCW 7.70.065 ☐ Health Care Agent (DPOAHC)	PRINT — Physician/ARNP/PA-C Name ✗ Physician/ARNP/PA-C Signature *(mandatory)*	Phone Number Date *(mandatory)*
PRINT — Patient or Legal Surrogate Name		Phone Number
✗ Patient or Legal Surrogate Signature *(mandatory)*		Date *(mandatory)*

Person has: ☐ Health Care Directive (living will) ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 8/2017

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

See back of form for non-emergency preferences ▶

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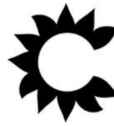

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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient and Additional Contact Information (if any)

Patient Name (last, first, middle)	Date of Birth	Phone Number
Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number

D Non-Emergency Medical Treatment Preferences

Antibiotics:

☐ Use antibiotics for prolongation of life.
☐ Do not use antibiotics except when needed for symptom management.

Medically Assisted Nutrition:
Always offer food and liquids by mouth if feasible.

☐ No medically assisted nutrition by tube.
☐ Trial period of medically assisted nutrition by tube. (Goal: ______________________________)
☐ Long-term medically assisted nutrition by tube.

Additional Orders: (e.g. dialysis, blood products, i[mp]lanted cardiac devices, etc. Attach additional orders if necessary.)

SAMPLE

✗ Physician/ARNP/PA-C Signature	Date
✗ Patient or Legal Surrogate Signature	Date

Directions for Health Care Professionals

NOTE: A [pe]rson with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

Completing POLST

- Completing a POLST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their surrogate and medical provider based on the person's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

This POLST is valid in all care settings including hospitals until replaced by new physician's orders.

The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

SECTIONS A AND B:

- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the person should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective" or "Full Treatment."

SECTION D:

- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing POLST

This POLST should be reviewed periodically whenever:
(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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For more information on POLST visit www.wsma.org/polst.

OVER ►

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