Arizona POLST
A Participating Program of National POLST

Advance Care Planning for the Seriously Ill

Advance care planning helps ensure patient treatment preferences are documented, regularly updated, and respected. There are three documents used to record these preferences: advance directives, prehospital medical care directive and POLST forms. These three documents differ in many ways; however, they can work together in approaching end-of-life planning. We will discuss their differences and clarify misconceptions about POLST and its relationship to advance directives and the prehospital medical care directive.

Arizona Advance Directives and POLST Forms

There are two types of advance directives, which can standalone or be combined: living wills and health care proxy. Living wills identify types of treatment a patient wants or does not want if they are terminally ill or in a vegetative state and lack decision-making capacity. A health care power of attorney document identifies a surrogate to make decisions when the patient lacks decision-making capacity. All competent adults over the age of 18 should be encouraged to have an advance directive and a healthcare power of attorney.

POLST is not an advance directive but is an actionable medical order, although not in the traditional sense. POLST is only for seriously ill patients for whom their healthcare professional would not be surprised if they died in the next year. It would be inappropriate for a healthcare professional to complete a POLST form for a patient who is outside the intended POLST patient population.

The prehospital medical care directive is not an advance directive but is an out of hospital do not resuscitate form. It is similar to the POLST form but it only addresses do not resuscitate and is primarily used by emergency medical services.

While these are all complementary documents they do not supplant each other; they complement each other. Most importantly, all three documents encourage needed advance care planning conversations among loved ones to understand a patient's goals of care and treatment preferences, so they can be honored when the patient is unable to speak for him/herself. It is only through these ongoing conversations, and revisions of documents are necessary, to ensure patient treatment desires are honored.

Thoughtful Life Conversations

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These documents are only as good as the conversation and information shared prior to completing them. POLST creates the opportunity to have a more specific advance care planning conversation than is likely to occur with an advance directive.

POLST is not just a piece of paper but also the culmination of a shared decision- making process between the patient and his/her healthcare provider. The healthcare provider identifies and discusses the patient's specific diagnosis, prognosis, and treatment options (including the benefits and burdens of each). The patient shares his/her values, beliefs and goals of care. Using all that information, the healthcare provider and patient work together to make decisions about desired treatment. The healthcare professional completes the POLST, documenting the decisions; it is only after this conversation that the patient and the healthcare provider signs the POLST form.

The healthcare power of attorney stands in the patient's shoes when the patient lacks capacity providing direction to the healthcare team on the patients desired treatment. The longer patients, healthcare powers of attorneys and surrogates, loved ones and healthcare professionals have engaged in advance care planning conversations, the more likely the parties will be able to ensure a patient's wishes are identified and honored.

It is the standard of practice that healthcare professionals be trained in conducting shared decision-making discussions with patients and families so POLST forms are properly completed.

Similarities and Key Differences

All advance care planning documents are voluntary. Both the Advance Directive and the POLST document patient treatment preferences and goals of care.

Unfortunately, confusion about these documents persists, leading some individuals to consider only one of them while ignoring the potential benefit of the other. Clinical experience and research demonstrate that advance care directives are not sufficient to ensure that care goals of patients with serious advanced illnesses will be honored unless an POLST form is also completed.

The key similarities and differences between these documents are presented in the Table1 and 2 below:

Table 1. How is POLST Different Than an Advance Directive?

Characteristics	**POLST**	**Advance Directive**
Who Should Use It?	Only for the seriously ill	All adults (18+)
Time Frame	Applies to Current Care	Applies to Future Care
Who Completes the Form?	Healthcare professionals with the patient/family	Patient(s)
Resulting Form	POLST	Living Will; Healthcare Power of Attorney
Healthcare Agent or Surrogate Role	Can engage in discussion if patient lacks capacity	Cannot complete
Portability	Healthcare provider responsibility with patient/family	Patient/family responsibility
Periodic Review & Updating	Provider responsibility: periodically & when there is a change in the patient's condition	Patient/family responsibility
Who Signs	Patient & Healthcare Provider (Physician, NP, PA)	Living Will & Healthcare Power of Attorney: Patient and Witness or Notary

Table 2. How is POLST Different Than a Prehospital Medical Care Directive?

POLST	**Prehospital Medical Care Directive**
Can choose or refuse resuscitation	Would only use if choosing Do Not Resuscitate
Patient may choose to receive other medical treatments: Full treatment Selective Interventions Comfort Measures (Allow Natural Death/AND) Medically Assisted Nutrition	Only applies to resuscitation (in the event of cardiac or respiratory arrest)
Honored across all care settings	Only honored outside the hospital by EMS and first responders
Not currently regulated by Arizona statutes, but POLST form could be used with an Advance Directive, which is regulated	Currently in legislation: Must be on the statutorily prescribed form Must be on orange paper
Requires conversation with physician/NP/PA and patient on prognosis, treatment goals of care (informed consent and shared decision making)	Completed by physician, patient and witness
Signed by patient and physician/NP/PA	Signed by patient, witness and provider

Completion of Document

Completion of an advance directive does not require assistance by a healthcare professional; individuals can complete them on their own. Signatures required to make an advance directive valid in Arizona include the signature of the patient and a witness or a notary. POLST forms are completed and signed by healthcare professionals and the patient. Arizona is an endorsed state by National POLST. Education for healthcare professionals on how to properly complete POLST forms is recommended. The prehospital medical care directive requires the signature of the healthcare professional and the patient.

Document Language

Advance directives generally have language that may not be understood by the general public and does not clearly define treatment options. Consequently, a patient's advance directive may be vague and not easily interpreted. As a result, when reviewing an advance directive for treatment options, the healthcare professional and healthcare power or attorney/surrogate may be required to speculate what the patient would have wanted in the specific medical circumstance. POLSTs have specific language about treatment options so they are easily interpreted and followed. POLST turns patient treatment preferences and goals of care documented in an advance directive into medical orders that may be followed in an emergency. The prehospital medical care directive form is limited solely to "do not resuscitate" and does not address other treatment options.

Timing of Document Completion

While all three advance care planning forms document future treatment preferences, advance directives and the prehospital medical care directives can be completed at any time since they document general wishes for an unspecified future medical crisis. POLST documents specific wishes based on specific knowledge of a patient's specific disease (and its progression). While the specifics of exactly what will happen as the disease progresses is unknown, the prognosis and understanding of the disease progression are known and the universe of possibilities is restricted.

Ease of Modification or Revocation

Modification or revocation of an advance directive, prehospital medical care directive and the POLST form requires the patient and witness or notary, and healthcare professional to void the previous document, complete a new document and to obtain new signatures. The POLST form is easily modified or revoked to allow patients to change treatment decisions as their disease progresses.

Accountability

If the advance directive is poorly written, confusing, contradictory, or not signed by all required parties, it may be invalid or not followed without anyone being accountable for such errors. As a medical order, only those professionals with training should complete an POLST form with the patient or surrogate and, further, the healthcare professional with authority to sign medical orders is responsible for reviewing the POLST prior to

signing to ensure the orders are consistent with the decisions reached during the shared decision-making process. The signing healthcare professional is accountable for the POLST orders.

Document Review During a Medical Crisis

In a medical crisis, emergency medical service (EMS) personnel institute cardiopulmonary resuscitation and other life support measures unless they have medical orders to the contrary. Advance directives are not medical orders, so EMS personnel cannot follow them; instead, they are generally reviewed (if they can even be located) once the patient has been transported to the health care facility.

The prehospital medical care directive, by law must be on orange paper, and was developed by EMS to communicate the patient does not want to be resuscitated. This is frequently located on the patients' refrigerator or front door. The prehospital medical care directive does not address other treatment or care options such as comfort care or selective care.

As medical orders, POLST forms are followed in times of crisis by EMS personnel in accordance with protocol, and by treating health care professionals, including physicians. Since an POLST form is brightly colored on pink paper and included in a patient's medical record, it is easily located.

Discussion

Some POLST opponents have stated that conversations with patients and their healthcare professionals suffice for advance care planning, but conversation alone is not a viable alternative to ensure others know the patient's goals of care and treatment wishes. During emergencies, EMS personnel follow protocols. They cannot follow requests from surrogates, interpret advance directives, and they generally do not have time to identify and call the patient's healthcare professionals to ask for orders. The POLST form is patient-centered and honors patients' moral and religious beliefs. For example, it allows Catholics to make decisions consistent with the United States Conference of Catholic Bishops Ethical and Religious Directives for Catholic Health Care Services, 5th ed. (2009) and ensures that those decisions will be honored in an emergency and across care transitions. The POLST form allows healthcare professionals to work with the patient (or his/her surrogate) to order treatments the patient wants and to ensure that treatments the patient considers "extraordinary" and/or excessively burdensome not be provided.

Further, the POLST form requires that "ordinary" measures to improve the patient's comfort and food and fluid by mouth, as tolerated, always be provided.

National POLST recognizes that allowing natural death to occur is not the same as killing. Euthanasia/Medical Aid in Dying is illegal in Arizona, and POLST forms do not allow for active euthanasia or physician-assisted suicide.

If the patient wants their POLST form to be part of the Arizona state registry it should be attached as an addendum with the Living Will and sent to the Secretary of State's office with the Living Will. It is the patient's responsibility to share a copy of the advance care planning forms with their healthcare proxy and surrogate. The healthcare provider signing the POLST form is responsible to ensure it is in their electronic medical record.