# Washington POLST Clinician Toolkit

## Advance Care Planning: Advance Directives & POLST

This document will show advance care planning, advance directives, and POLST all work together to guide an individual's health care decisions at different stages in their life.

This document is one resource of the *Washington POLST Clinician Toolkit* and is intended to be used in conjunction with the other documents. To find the full *Washington POLST Clinician Toolkit*, please visit: https://www.honoringchoicespnw.org/polst-toolkit/

### The Process of Advance Care Planning

Advance care planning is for every individual 18 years and older. Health care providers can normalize and support this by making it a routine part of primary and specialty care. It is an ongoing process between individuals, those important to them, and the health care team. Advance care planning and resulting documentation, if any, can become more focused, over time, on specific expected outcomes related to the individual's disease or condition. [iii]

### Advance Directives

An individual's expressed goals, values, and preferences can be documented in an advance directive. An advance directive includes the following:

- Durable Power of Attorney for Health Care (Legal Document)
  - Names the health care agent(s). The Honoring Choices PNW DPOA-HC also helps you prepare the health care agent by sharing goals, values, and preferences.
- Health Care Directive/Living Will (Legal Document)
  - Guides decisions on whether to withhold or withdraw life-sustaining treatment at the end of life.
- Personal Statement
  - Summarizes an individuals' values and goals relating to future medical care.

### POLST

Portable Orders for Life-Sustaining Treatment (POLST) is a set of medical orders that is designed to communicate an individual's treatment wishes about emergency care to emergency medical services (EMS) providers health care teams when the individual is unable to speak for themself.

While written documents are preferred, please remember they are *voluntary*; no person should be required or coerced to complete an advance directive or POLST.


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## Comparison of Advance Directives and POLST

| | Advance Care Planning Documentation | | |
|---|---|---|---|
| | Advance Directives | | POLST |
| | Durable Power of Attorney for Health-Care (DPOA-HC) | Health Care Directive (i.e., Living Will) | |
| **What is it?** | Legal document | Legal document | Medical orders |
| **What does it do?** | Names health care agent. The Honoring Choices PNW DPOA-HC also prepares the health care agent by including an individual's goals, values, and preferences. | Guides decisions on whether to withhold or withdraw life-sustaining treatment at the end of life. | Actionable, portable orders for emergency medical services. |
| **Who is it for?** | Any adult with capacity. | Any adult with capacity. | Individuals with a serious life-limiting medical condition, regardless of capacity. |
| **Who can complete it?** | Only the individual. | Only the individual. | Individuals or their legal medical decision maker. |
| **How is it used?** | Used primarily in a hospital setting when individual does not have capacity. | Used primarily in a hospital setting when individual does not have capacity. | Emergency medical services use in out-of-hospital emergencies. |

*Table 1: This comparison reviews elements of advance care planning documentation.*

## Advance Care Planning in Practice

Both advance directives and POLST are advance care planning documents that can work together to communicate a spectrum of patient-centered, value-informed decisions when an individual is unable to make medical decisions for themself. Health care teams play an active role in promoting and facilitating the advance care planning process with all adults.

For individuals with progressive disease or serious illness or conditions, health care providers (MD, DO, ARNP, PA-C) play an essential role in discussing their medical prognosis and the implications of pursuing different medical treatment options. These types of conversations are referred to as goals of care conversations, thus differentiating them from advance care planning for healthy individuals.

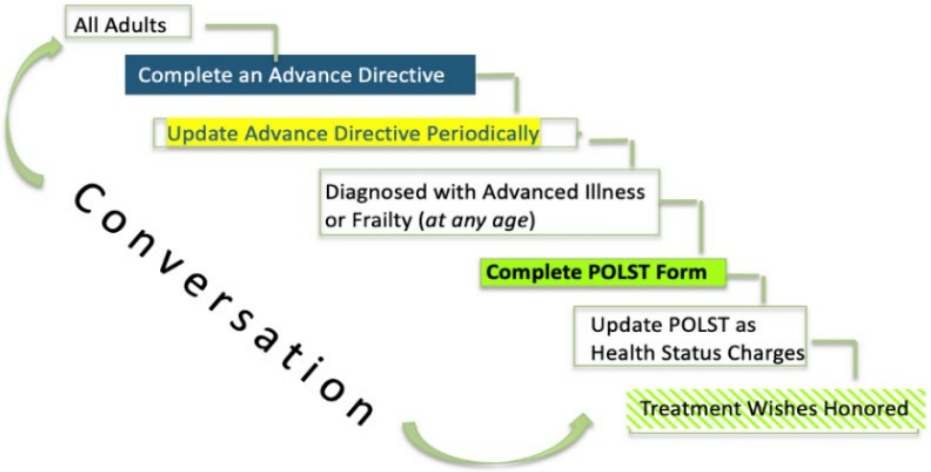


*Image 1: Advance care planning over the lifespan. Adapted with permission from California POLST Education Program. © January 2010 Coalition for Compassionate Care California.* [iii][iv]

This ladder diagram shows how healthy adults should create advance directives, and how over time, or with progressive medical problems, the conversations are more disease-focused and can lead to the completion of POLST. The arrows on either end of the conversation indicate that at each step, more conversation continues to occur, to ensure that the documents are in alignment with and reflect the individual's goals, as they may change in the face of illness.

*Example case: Two years ago, Alex Person, who will be referenced as an example throughout this toolkit, attended an advance care planning workshop*

**Patient demographics, at the time of the workshop:** Alex Person, 64 y.o. female, mild asthma, osteoarthritis.
**Identified goals and preferences:** Her husband and three adult children are important to her. Sharing her stories and letters with her friends and family is her primary source of joy. She gets a lot of enjoyment from activities, such as hiking and boating. Maintaining the ability to communicate is important for her.
**Decisions:**
She wants all emergency measures done.
Use all reasonable measures to prolong life, but to stop if end of life is inevitable or would involve artificial means of support for nutrition or other vital signs, or if quality of life would require prolonged care outside the home. She does not want to be on machines to stay alive
Names her husband Nate as health care agent.
**Documentation:** Completed her health care directive and durable power of attorney for health care. POLST was not offered due to her health status and her expressed decision to have all emergency measures done.

[i] Butler M, Ratner E, McCreedy E, Shippee N, Kane RL. Decision Aids for Advance Care Planning: An Overview of the State of the Science. Ann Intern Med. 2014 Jul 29
[ii] Dr. Robert Bree Collaborative. End-of-Life Care Report and Recommendations. 2014 Nov 21
[iii] Coalition for Compassion Care of California. California POLST Education Program. Coalitionccc.org. 2010 Jan
[iv] National POLST Paradigm. Polst.org.n.d.