**Background:**
- Strong patient autonomy climate
- Interagency desire for collaboration to improve end of life care
- Promote informed patient decision making

**Grassroots Efforts**
Pilot POLST in several communities first to show safety/efficacy.
Educate health care providers & legislators about POLST.
Participate in the local and statewide conversations on POLST,
including EMS, hospitals, home health, hospice, legislators, patient
advocates, religious leaders, and payer groups.

**Resources:**
- **Statewide Champions**
- **Arizona POLST Task Force**
- **Arizona Hospital and Healthcare Association**
- **Arizona Thoughtful Life Conversations**
- **Regional Community Champions**
- **Northern Arizona Healthcare**
- **Flagstaff Emergency Physicians**
- **Pre-hospital Program Coordinator & EMS Medical Directors**
- **Northern Arizona University—School of Nursing**

**Unique Barriers:**
- Current legislation regarding DNR (orange PMCD), artificial
  nutrition, and surrogacy
- Lack of knowledge and misinformation
- Communication infrastructure
- Rural population
- Cultural taboos on discussing end of life decisions

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

**Definition:**
- A medical order set describing patients’ wishes regarding medical treatments
- Follows the patient across healthcare settings
- Directed towards patients with serious life limiting illnesses with
  a life expectancy of 12 months or less
- Focuses on
  - Cardiopulmonary resuscitation
  - Respiratory interventions
  - Use of antibiotics
  - Medically assisted nutrition

**National Trends:**
- Currently, 46 states have POLST programs, from developing to mature.
- Arizona is “in development” for POLST.

**Expected Outcomes and Benefits of Pilot:**

**Patient**
- Support informed patient choice
- Improve end of life care and quality of life
- Improve communication of patient and healthcare providers
  about end of life treatments and goals of care

**Community**
- Promote continuity of care and end of life conversations
- Improve education and preparedness of health care providers
- Identify barriers to state-wide use

**State**
- Provide Arizona an example on how to implement POLST within
  a community
- Provide evidence to support potential legislative changes

**Phase One: Initial Activity** (2015-2016, funded by NAH)

**Study Protocol**
- All Stage C or D Congestive Heart Failure patients admitted to
  FMC screened for inclusion.
- Patient or surrogate introduced to POLST during hospitalization
  culminating in POLST form completion.
- Followed every 3 months by phone & chart review.

**Institutional Support**
- Education of Palliative Care, Case Management, ED, EMS
- Addressing policies via EMS and Flagstaff Medical Center

**Study Results**
- Of 82 patients approached, 66 completed a POLST (80%).
- Population: 65% seen by PC, 28% Navajo
- Communication: 89 follow up phone calls (incomplete)
  - 15% felt it helped communication
  - 75% had contact with healthcare, 15% shared POLST
  - 36% lost or forgot form

**Phase Two: THRIVE Grant** (NAH and NAU collaboration)

**Address opportunity to improve communication via education & exposure.**
- Increase the sample size with more diverse hospitalized patient population.
- Include any individual with medical/physical frailty PLUS positive surprise
  question.
- Screening order under nursing & social work scope of practice.

**Educate Community Health Care Providers**
- Educate staff nurses & physicians about the POLST study and encouraging
  them to refer patients to the POLST team.
- Sponsor a regional Palliative Care conference for health care providers,
  including POLST information.
- Educate lay community.