What Makes Sense to the Patient: How to Use POLST Effectively

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Objectives

1. Describe how to start a serious illness conversation.
2. Define what topics are covered in the Serious Illness Conversation Guide and POLST.
3. Identify when and where to introduce the POLST conversation.

Have you Heard Any of These?

- "Do everything!"
- "Keep me (my loved one) alive!"
- "I don't want to lose them."
- "I'm not ready to let go."
- "CPR works. I've seen it on TV!"
- "I don't want to be a vegetable."

"There's no easy way I can tell you this, so I'm sending you to someone who can."

The Impact of Unwanted, Uncoordinated Treatment

30% of treatment is unwanted, unnecessary, non-beneficial

(Shrank et al, 2019)

The Impact of Unwanted, Uncoordinated Treatment

- 30% of treatment is unwanted, unnecessary (IHI, IOM, 2014)
- Sentinel Event- Joint Commissions
  1.. Human factors
  2. Leadership
  3. Communication
  4. Assessment
  5. Information management
  6. Physical environment
  7. Continuum of care
  8. Operative care
  9. Medication use
  10. Care planning
- Patient and Family Satisfaction
- Decreased distress
- Improve Trust / Communication

Serious Illness

A health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregiver.*

*Kelley, AS, Bollens-Lund, E. Identifying the population with serious illness: the "denominator" challenge. Journal of Palliative Medicine. Volume: 21 Issue S2: March 1, 2018.

Your Role in Conversations

- Identification
- Education
- Clarification
- Teach Back
- Follow-through

Advance Care Planning: *Definition*

Advance care planning (ACP) is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of ACP is to help ensure that people receive medical care that is consistent with their values, goals, and preferences.

(Sudore et al, 2017)

Elements of Advance Care Planning (ACP)

ACP is a process of planning for future medical decisions. To be effective, this process includes

- **Reflection** on goals, values, and beliefs (including cultural, religious, spiritual, and personal)
- **Understanding** of possible future situations and decisions
- **Discussion** of these reflections and decisions with those who might need to carry out the plan

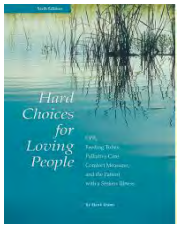
(Respecting Choices®, 2018)

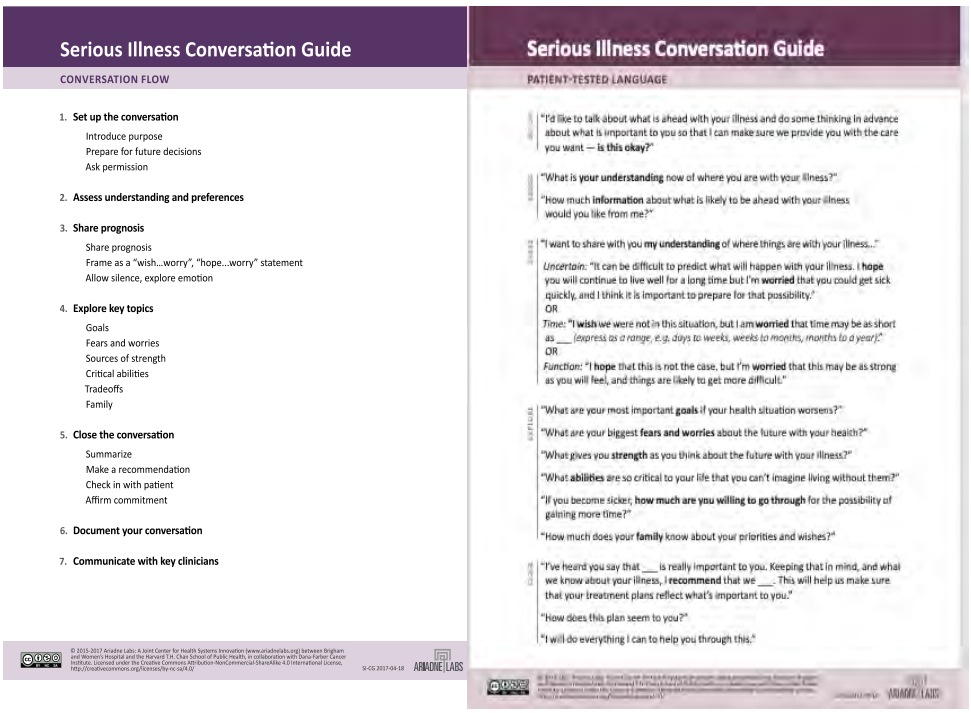
Patient Education Resources

Ice Breakers
- Go Wish Game
- Hello, Common Practice Game

Hard Choices for Loving People Booklet

Gone From My Sight Booklet Booklet





Serious Illness Conversation Guide

CONVERSATION FLOW

1. **Set up the conversation**
   - Introduce purpose
   - Prepare for future decisions
   - Ask permission
2. **Assess understanding and preferences**
3. **Share prognosis**
   - Share prognosis
   - Frame as a "wish…worry", "hope…worry" statement
   - Allow silence, explore emotion
4. **Explore key topics**
   - Goals
   - Fears and worries
   - Sources of strength
   - Critical abilities
   - Tradeoffs
   - Family
5. **Close the conversation**
   - Summarize
   - Make a recommendation
   - Check in with patient
   - Affirm commitment
6. **Document your conversation**
7. **Communicate with key clinicians**

SI-CG 2017-04-18

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Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"

"What is **your understanding** now of where you are with your illness?"

"How much **information** about what is likely to be ahead with your illness would you like from me?"

"I want to share with you **my understanding** of where things are with your illness…"

Uncertain: "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility."
OR
Time: "**I wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*."
OR
Function: "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."

"What are your most important **goals** if your health situation worsens?"

"What are your biggest **fears and worries** about the future with your health?"

"What gives you **strength** as you think about the future with your illness?"

"What **abilities** are so critical to your life that you can't imagine living without them?"

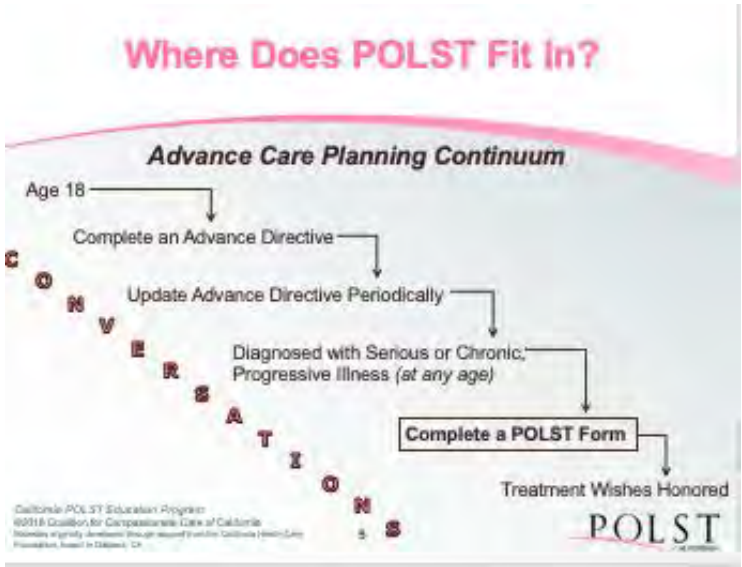
"If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?"

"How much does your **family** know about your priorities and wishes?"

"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you."

"How does this plan seem to you?"

"I will do everything I can to help you through this."



National POLST

The National **POLST** is an approach to end-of-life planning that emphasizes patients' wishes about the medical treatments they receive.

The decisions from these conversations may be documented as actionable medical orders on a **POLST** form.

What is POLST?

POLST is a actionable, portable medical order

A tool to improve the quality of patient care and reduce medical risks

- Identifies patients' values and wishes regarding medical treatment
- Communicates and respects patient's wishes by creating portable medical orders.

Key Components:

- Thoughtful, facilitated advance care planning conversations
- Between health care professionals and patients and those close to them
- Determines what treatments patients **do and do not want**
- Based on their personal beliefs and current state of health.

Why POLST?

- A tool – improves patient care quality / reduces medical
- Identifies patients' values and wishes regarding medical treatment
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Who Should Have a POLST ?

- Not for everyone
- Patients with serious illness, frailty
- The Surprise question:

"Would you be surprised if this patient died in the next 1-2 years?"

Key Components of POLST Paradigm

- Standardized practices, policies and form- Coalition
- Education and Training
  - Advance care planning facilitators
  - System implementation
- Timely discussions along continuum prompted by:
  - Identification of appropriate cohort
  - Prognosis
- Medical orders honored throughout the system
- Quality improvement process for form and system

Key Components of the POLST (continued)

- Form allows for clear directions about other life-sustaining treatment
- Form transfers with the patient
- Health professionals are trained to use the form and to have discussion to complete the form.
- Measures are made to monitor the success of the program and its implementation

Comparing POLST Form to Healthcare Directive

	Healthcare Directive	POLST Paradigm Forms
Population	All adults >18 y.o.	Any age, serious illness, at end of life or frailty
Time Frame	Future care/future conditions	Current care/current conditions
Where Completed	Any setting, not necessarily medical	Medical setting
Resulting Product	Healthcare agent appointed and/or statement of preferences	Medical orders based on shared decision making
Healthcare Agent Role	Cannot complete	Can consent if patient lacks capacity
EMS Role	Does not guide EMS	Guides EMS as a medical order
Portability	Patient/Family Responsibility	Healthcare Professional Responsibility
Periodic Review	Patient/Family Responsibility	Healthcare Professional Responsibility

Explaining POLST to Families

NATIONAL POLST PARADIGM
PROGRAM DEVELOPMENT GUIDE

- **POLST is a process and a form**
- POLST has different names in different states. At the national level, it is simply called **POLST: Portable Medical Orders**, or POLST for short. Portable means that the order is valid outside the clinic or doctor's office, similar to a drug prescription.

POLST is many things, including:

- **A process**. Part of advance care planning, which helps you live the best life possible.
- **Conversation**. A good talk with your provider about your medical condition, treatment options, and what you want.
- **A medical order form** that travels with you (called a POLST form).

Explaining POLST to Families (cont.)

POLST communicates your wishes as medical orders

- A POLST form tells **all** health care providers during a medical emergency what you want:
- "Take me to the hospital" or "I want to stay here"
- "Yes, attempt CPR" or "No, don't attempt CPR"
- "These are the medical treatments I want"
- "This is the care plan I want followed"

POLST is for the seriously ill or frail

- POLST gives seriously ill or frail people more specific direction over their health care treatments compared to advance directives and more options than Do Not Resuscitate (DNR) orders.

Explain Default Policy

"It is very important that you understand that it is our policy is always to provide all life sustaining treatments for any patient that has not told us that the treatments that they do not want."

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Tools to Get Started

- Go Wish Game
- Hard Choices For Loving People (Hank Dunn)
- Serious Illness Care Resources
- The Conversation Project Starter Kits
- National Healthcare Decisions Day- April 16
- MyDirectives app
- Honoring Choices® North Dakota

Healthcare Directive & POLST Resources

- ND- Honoring Choices® North Dakota, ND POLST
- Your Guide to POLST
- National POLST
- Article, *The Pearls of POLST*
- *ND POLST CME- online*
- *ND POLST Scripting CE opportunities*

Ain't the Way to Die Video –Z Dogg MD (Warning-Graphic)

https://youtu.be/NAlnRHicgWs?t=5

https://zdoggmd.com/aint-the-way-to-die/

How Hope Grows & Other POLST Videos

https://polst.org/

When to Start?

TODAY!

First and foremost, lead by example - be sure you have thoughtfully considered and made your own healthcare decisions known.

"The future depends on what we do in the present"

–Mahatma Gandhi

For More Information

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