Steps to Implement a POLST Paradigm Program

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Objective

- Identify steps to implement a POLST Paradigm system in a state or region
- Demonstrate how these steps work

Implementation Steps

- Needs Assessment
- Core Working Group
- Task Force – Collaborative Model
- Program Coordination
- Key Components
- Legal Issues
- Pilot Project
- Education and Training
- Distribution and Fulfillment
- Program Requirements
- Relationship to Media
- Available Resources

Needs Assessment

- System responsiveness
- Honoring patient preferences for EOL care
  - DNR, Life-sustaining Treatment, Site of Death
- Interdisciplinary Approach
  - Facilities: hospitals, SNFs, ALFs, DM programs
  - Disciplines: MD, RN, SW, EMS, Atty, consumers
- Data-driven
- Build on current research

Core Working Group

- Assemble a workgroup
- Broad representation – interdisciplinary
- Leadership
- Passion, commitment
- Willing to outreach and educate
- Sustainability
- Expand collaboration

Task Force – Collaborative Model

- Broad representation: state, regional & local
  - Department of Health
    - Hospital, LTC, EMS oversight, surveyors
  - EMS
  - Hospital Association
  - Long-term Care Associations (NFP and FP)
  - Hospice and Home Health
  - Office for Aging, Society on Aging, Ombudsmen
  - Medical Society
  - Bar Association

Program Coordination

- Leadership
- Operations
  - Distribution and Fulfillment
  - Training
  - Quality Improvement
  - Share best practices & lessons learned
- Funding
- Sustainability
- Variation in models

Key Components

- Standardized practices, policies and form
- Education and Training
  - Advance care planning facilitators
  - System implementation
- Timely discussions along continuum prompted by:
  - Identification of appropriate cohort
  - Prognosis
- Clear, specific language on actionable form
- Bright colored, easily recognized form
- Medical orders honored throughout the system
- Quality improvement process for form and system

Core Working Group

- Educate and empower
  - Research - Evidence base
    - View www.polst.org
  - NQF Preferred Practices
  - Web resources
    - State-specific information
    - State contacts
    - Links to other state web sites

Web Site Resources

www.polst.org	Center for Ethics in Health Care Oregon Health & Science University
www.wvendoflife.org	West Virginia Center for End-of-Life Care: POST
www.wsma.org/patients/polst	Washington State Medical Association: POLST
www.compassionandsupport.org	New York State Community-Wide End-of-life/ Palliative Care Initiative: MOLST
www.eperc.mcw.edu	End of life and palliative care education resource center
www.hardchoices.com	"Hard Choices for Loving People": A resource for professionals, patients and their families regarding end-of-life treatment decisions

Advance Care Planning Community Goals

- Document the designated surrogate/decision maker in accordance with state for every patient in primary, acute and long-term care and in palliative and hospice care.
- Document the patient/surrogate preferences for goals of care, treatment options, and setting of care at first assessment and at frequent intervals as condition changes.

National Quality Forum, Framework and Preferred Practices for Quality Palliative Care & Hospice Care, 2006

Advance Care Planning Community Goals

- Convert the patient treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital care through a program such as the POLST Program.

National Quality Forum, Framework and Preferred Practices for Quality Palliative Care & Hospice Care, 2006

Advance Care Planning Community Goals

- Make advance directives and surrogacy designations available across care settings
- Develop and promote healthcare and community collaborations to promote advance care planning and completion of advance directives for all individuals (e.g. the Respecting Choices and Community Conversations on Compassionate Care programs.)

National Quality Forum, Framework and Preferred Practices for Quality Palliative Care & Hospice Care, 2006

Legal Issues

- State regulations or need for legislation
  - Legislative approach (WV, TN, HI)
  - Regulatory approach (OR, UT, WA)
  - Hybrid approach (NY)
- Patient's/legal agent's signature
  - Mandatory or optional
- Practitioner's Signature other than MD
  - Need for legislation, potential opposition
  - Acceptable policies & procedures with current regulations

Pilot Project

- Voluntary
- Community consensus of key players
- Training
- Distribution & fulfillment of materials
- Establish key outcomes
- Measure regularly
- Share results with key stakeholders

Education and Training

- Advance Care Planning Facilitators
  - Traditional advance directives
  - POLST Paradigm form
  - Goal-based, patient-centered discussions
  - Patient-centered program and process
    - not merely the form
- Program Implementation
  - Facility-based
  - Physician practice – opportunity for process improvement
- Community education

Distribution and Fulfillment

- Distribution Center
  - Process to order forms, educational and training resources
- Download from web site
- Considerations
  - Funding
  - Tracking utilization and implementation

Program Requirements

- Review requirements on-line, view http://www.ohsu.edu/polst/corereqs.shtml

- Apply on-line for endorsement, view http://www.ohsu.edu/polst/coreform.shtml

Relationship to Media

- Communication Plan
- Messaging
  - Consistent message
  - Approach to avoid
- Prepare for interviews
  - Consider 3 key messages

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MOLST
MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT

Thank You

For further information , view

www.compassionandsupport.org

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