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](http://www.polst.org)
  - NQF Preferred Practices
- Web resources
  - State-specific information
  - State contacts
  - Links to other state web sites
## Web Site Resources

<table>
<thead>
<tr>
<th>Website</th>
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<td><a href="http://www.polst.org">www.polst.org</a></td>
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<td><a href="http://www.compassionandsupport.org">www.compassionandsupport.org</a></td>
<td>New York State Community-Wide End-of-life/Palliative Care Initiative: MOLST</td>
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<td><a href="http://www.eperc.mcw.edu">www.eperc.mcw.edu</a></td>
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<td><a href="http://www.hardchoices.com">www.hardchoices.com</a></td>
<td>“Hard Choices for Loving People”: A resource for professionals, patients and their families regarding end-of-life treatment decisions</td>
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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 transferrable 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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Thank You

For further information, view

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