POLST Conversation & Documentation

A key component to advance care planning is thoughtful, facilitated conversations between health care professionals and patients and those close to the patients, particularly the individual the patient has identified as his/her surrogate. Patients should be encouraged to both (a) let the individual the surrogate know they have been named and (b) include the potential future surrogate in the advance care planning conversations so the surrogate is aware of the patient's values and beliefs. Including the surrogate in these conversations will help the surrogate feel more comfortable making person-centered goals of care treatment decisions when necessary.

Conversation and discussion notes should be documented in the medical record.

General ACP Conversation Training

Physicians, clinicians and all other staff members require training based on their clinical roles, within scope of practice, and their administrative roles. Additional training will be required for physicians, nurse practitioners, physician assistants and nurses involved in thoughtful POLST conversations. To be successful, all staff members need a basic understanding of the value of advance care planning. At the end of the initial basic training, staff will be able to:

1) Review advance care planning as a communication process, a wellness initiative, a key pillar of palliative care and an integral component of the practice of medicine.
2) Discuss key barriers and ways to overcome those barriers.
3) Explain the difference between advance directives and medical orders (POLST Forms).

Basic training for all staff members on advance care planning includes each staff member learning the value of advance care planning, as well as the differences between advance directives and POLST Forms, and participating in their own advance care planning. Basic training can be self-directed or via use of videos and discussion with colleagues.

Videos that share real stories from real patients and families who have experienced serious illness or traumatic events where advance care planning was needed provide an excellent training tool to illustrate the value of advance care planning for everyone 18 years of age and older, as well as the value of offering the POLST Paradigm Program to appropriate patients.

1) Advance Care Planning and Advance Directives
   a) The Conversation Project: website and video.
   b) Community Conversations on Compassionate Care: website, booklet, video.
   c) Prepare for Your Care: website, pamphlet, video.
   d) Additional available advance care planning resources are available here.
2) Advance Care Planning and the POLST Paradigm: videos, resources and website.
   a) Review available state specific patient brochures, consumer guidelines here.
   3) Review the Advance Care Planning Clinical Pathway for Persons with a Life Expectancy Greater Than 1 Year. An interactive teaching version is available here.
4) Review the Advance Care Planning Clinical Pathway for Persons with a Life Expectancy Less Than 1 Year. An interactive teaching version is available here.
5) Review ACP screening questions, office workflow, Ten Steps to Pre-Visit Planning: Integrate ACP & POLST, P&P. Developed for the Medicare Annual Wellness Visit (AWV), screening questions can be used for all patients 18 years of age and older.
6) Staff members should participate in personal advance care planning. Choose a surrogate. Have a family discussion; share their values, beliefs and goals for care. Complete an advance directive.

POLST Conversations

The POLST form is completed as a result of the process of shared decision-making. During the conversation, the patient shares his or her values, beliefs, and goals for care, and the health care professional explains the patient's diagnosis, prognosis, and treatment alternatives, including the benefits and burdens of life-sustaining treatment. Together they reach an informed decision about desired treatment, based on the person's values, beliefs and goals for care. These conversations should be documented in the patient's medical record, irrespective of whether a POLST form is completed.

Regardless of setting, a POLST form should never be completed without a conversation between a trained health care professional and the patient or his/her surrogate. The POLST Paradigm encourages health care professionals be trained to conduct shared decision-making discussions with patients and families so that POLST forms are completed properly.

In addition to basic training for all staff members, additional training should be required for physicians, nurse practitioners, physician assistants, nurses and social workers participating in thoughtful POLST conversations, within scope of practice. At the end of this additional training, physicians, nurse practitioners, physician assistants, nurses and social workers will be able to:

1) Discuss the clinical process, the ethical framework, and the shared, informed medical decision-making process for making POLST decisions and define POLST Form elements.
2) Use effective communication skills and the 8-Step POLST protocol.
    a) View the series of videos in the "Using the 8-Step MOLST Protocol" Playlist: These videos feature active listening and discussions about specific aspects of end-of-life care including: resuscitation, intubation & mechanical ventilation, feeding tubes & IV fluids, and antibiotics.
3) Recognize the ethical framework for making decisions to withholding/withdrawing life-sustaining treatment apply *with or without a POLST Form.*

For the latest information on POLST Paradigm training, review the National website and your state POLST Paradigm program webpage (if available) and the POLST Paradigm FAQs and your state's POLST Paradigm Program's FAQs (if available).

Documentation

Documentation of the POLST conversation in the patient's medical record is critical.

1) Key elements that should be included in the synopsis of the discussion that is documented in the office note ("Remember, if you don't document, it didn't happen."):
    a) Patient's appropriateness for having a POLST Form, including medical condition(s), health status and prognosis
    b) Presence of any advance directive and ensure inclusion in the medical record
    c) Patient's capacity to make decisions to withhold and/or withdraw life-sustaining treatment
    d) Identify the appropriate surrogate and the ethical standard for making POLST Form decisions (known wishes or best interest)
    e) Patient's values, beliefs, goals for care and expectations
    f) Shared medical decision-making for POLST treatment decisions to withholding/withdrawing of life support
    g) If conflict exists, document how the conflict was resolved; for example, due to a complicated family dynamic

Additional documentation may be necessary for reimbursement of the conversation. Please see Reimbursing for the POLST Conversation for more information.