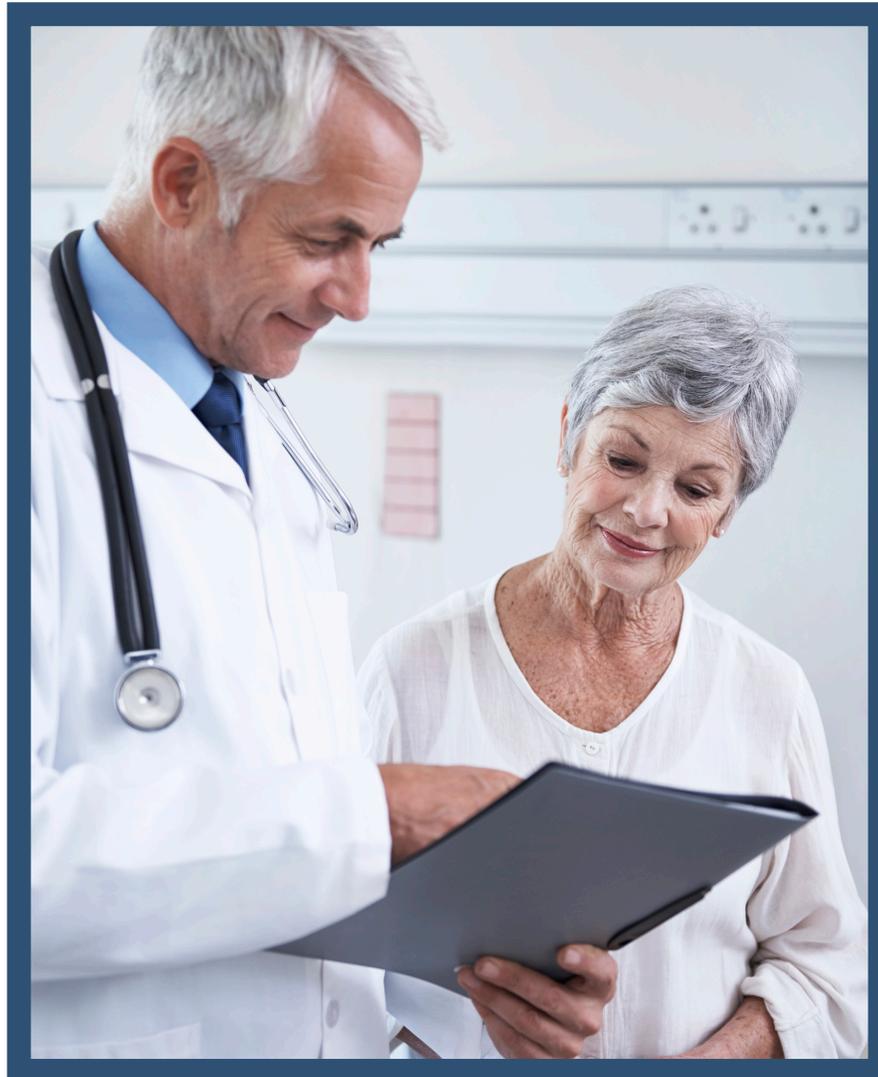


# POLST

## Conversation Guide



## POLST Introduction

The Physician Orders for Life Sustaining Treatment (POLST) was developed to improve the quality of patient care by creating a system to elicit patients' preferences regarding medical treatment, and communicate and honor those preferences by creating portable medical orders. Only patients with serious illnesses, frailty or those who are healthy and wish to limit certain medical interventions should have a POLST form.

A key component of the POLST system is thoughtful conversations between health care professionals and patients (and/or surrogates) to determine what treatments patients do and do not want based on their personal values and current state of health. In these conversations, patients/surrogates are informed of treatment options and, if they wish, their health care professional will complete a POLST form based on the patient's expressed treatment preferences. The completed POLST form is a standing medical order for emergent medical care.

The goal of this POLST Conversation Guide is to help prepare health care professionals to conduct these thoughtful conversations.

### Definitions:

- **Goals of Care Conversation (GoCC):** A discussion between a health care team member and a high-risk patient (or surrogate) that helps identify the patient's values, health care goals and decisions about life-sustaining treatments and other care.
- **Life-Sustaining Treatment (LST):** A medical treatment that is administered in an attempt to prolong the life of a patient who would be expected to die soon without the treatment.

Examples:

- Cardiopulmonary resuscitation (CPR)
- Mechanical ventilation
- Feeding tubes
- Dialysis

### CAPTURES: A Talking Map for GoCCs about LST:

- Capacity
- Authorized Surrogate and Advance Directives
- Perception of Illness and Prognosis
- Target Patient's Values and Goals
- Unite Values and Goals with Treatment Options
- Recommendations
- Empathize and Explore Challenges
- Summarize the Plan

## Discussion Steps and Tips

### CAPTURES: Capacity

- Capacity = A clinical judgment about a patient's ability to make a particular health care decision at a particular point in time.
- Ensure the patient can make decisions about LSTs. Capacity to make decisions about LST can be assessed throughout the LST goals of care conversation.
- A patient is considered to have decision-making capacity when they can do ALL of the following:
  1. Understand the nature, extent or probable consequences of health status and health care alternatives;
  2. Make a rational evaluation of the burdens, risks, benefits and alternatives of accepting or rejecting health care; and
  3. Communicate a decision.

## Discussion Steps and Tips

### CAPTURES: Authorized Surrogate, Advance Directives

- Verify whom the patient has authorized to make decisions for them if they lose decision-making capacity.
- Ask the patient to complete a Durable Power of Attorney for Health Care to name a health care agent (if not done previously or patient wishes to change surrogate).
- Begin with an introduction and give an overview of what you will discuss.
- Ask for permission to proceed with the discussion.
- If a goals of care conversation is warranted and the patient lacks decision-making capacity, the conversation can be conducted with the patient's **surrogate**. Decisions should be based on the patient's values, goals and preferences.

#### The UT Surrogate Hierarchy:

1. A health care agent appointed by the adult.
2. Legal or special guardian appointed by a court of law.
3. Next of kin, 18+ years of age, in the following order of priority: spouse, child(ren), parent(s), sibling(s), grandchild(ren), grandparent(s).
4. An adult who has exhibited special care and concern for the patient and knows the patient and the patient's personal values.

**Does a patient with a POLST need an advance directive? Yes.**

Advance Directive	POLST
For anyone 18 and older	For persons with serious illness and/or limited life expectancy at any age and/or someone who wants limits to life-sustaining interventions
Can be completed by the patient only (not their surrogate)	Can be completed by the patient or their surrogate with a licensed health professional
<b>Instructions for future treatment</b>	<b>Medical Orders for current treatment</b>
Can appoint a health care agent	Only legal mechanism for a Utahn to have a do not Resuscitate (DNR) order outside of a licensed health care facility
Does not guide emergency medical personnel	Can guide actions by emergency medical personnel

## Words that Work

### CAPTURES: Authorized Surrogate, Advance Directives

#### Introduce the conversation:

- It's important for me to understand what matters most to you as we look ahead and make plans for your care. This helps me make sure you get the care that helps you reach your goals. Can we spend a little time talking about this?
- Have you thought about whom you would want to make decisions for you if you were ever unable to make decisions for yourself?
- Have you completed an advance directive to name this person as your decision maker?

#### If the patient has not completed an advance directive:

- Since you haven't completed an advance directive naming a health care agent, in certain circumstances your health care team may need to turn to your [next of kin] to make health care decisions for you.
- If you don't want your [next of kin] to make health care decisions for you, you can name someone else in an advance directive. Would you like [our social worker] to help you with that?



## Discussion Steps and Tips

## Words that Work

### CAPTURES: Perception of Illness and Prognosis

- Patients cannot make informed decisions about goals and treatments when they don't know what to expect with their illness.
- If the patient is not aware of their prognosis, discuss prognosis with them and allow them time to adjust to the news. If discussing prognosis is out of your scope of practice, you can explore the patient's perceptions and refer to the appropriate medical team member for this discussion.
- If the patient has a different perception of their illness or prognosis, the medical team should spend time reframing the prognosis. The message is the patient has an illness that could get worse in the coming days, weeks or months and it is important to think about the future.
- Most patients will have an emotional response to hearing the reframe. This is normal.
- The emotional response may sound like a factual question:
  - Isn't there something else you can do?
  - Are you sure we've looked into everything?
- Respond to these questions with empathic statements (see page 7-8 for tips on responding with empathy).
- Ask permission before moving on.
- Goals of care should not be discussed at the same time as really serious news. Allow the patient time to adjust before proceeding with decisions, especially about LST.



### CAPTURES: Perception of Illness and Prognosis

#### Ask about perceptions of illness and prognosis:

- I have reviewed your chart and it would help me if you shared what your doctors have told you about your [name medical condition]?
- Tell me what you think the future might look like with your [medical condition].

#### Reframe - if the patient has a different perception of their illness or prognosis:

- Given where you are in your illness, it seems like a good time to talk about where to go from here.
- We're in a different place than we were [x] months ago.
- I can see that you are really concerned.
- I get a sense that this is not what you were expecting to hear today.
- Is it OK for us to talk about what this means?

### CAPTURES: Target Patient's Values and Goals

- You must know the patient's goals and values before creating a plan with them. How do you know what's important to the patient? Ask.
- If asked correctly, the question makes sense and isn't scary.
- The patient's values and priorities will help determine which treatment plan is right for the patient.
- No one wants LSTs; they are willing to undergo them to reach their goals.
- Patient goals are the **destination** and treatments are the **route** to get them there.



### CAPTURES: Target Patient's Values and Goals

- Given this situation, what matters the most to you?
- If it turns out that time is limited, what things would you want to do?
- As you think about the future, what are you worried about?

## Discussion Steps and Tips

### CAPTURES: Unite Values and Goals with Treatment Options

- Unite the patient's goals/preferences with treatment options that support their goals and are relevant to their medical condition.
- Asking patients if they would or wouldn't want an LST without discussing whether it supports their goals, assessing their understanding of the intervention, and determining their readiness to have the discussion can lead to poorly informed decisions.
- Assess the patient's understanding of the LST and readiness to discuss the intervention by asking an open-ended question such as, "has anyone talked to you about CPR; can you tell me what you know about it," instead of asking, "would you want CPR?"
- If the patient does not have a basic understanding of the LST, provide information to fill in the gaps.
  - Be clear and direct.
  - Avoid medical jargon.
  - Give 1-2 pieces of information at a time, then stop and wait for the patient to respond.



## Words that Work

### CAPTURES: Unite Value and Goals with Treatment Options

- I want to be sure you get the care that helps achieve your goals. It's helpful to know in advance whether you would or wouldn't want certain procedures. One of these procedures is CPR. Has anyone talked to you about CPR or have you seen it on TV?
- CPR is used only when your heart and breathing have stopped. Sometimes the heart and breathing stop as a natural part of the dying process. Other times it happens unexpectedly.
- Basic CPR involves forcefully pushing on the chest and blowing air into the lungs to try and restart the heart and breathing. Advance life support can include shocking the heart and putting a tube down the throat.

### CAPTURES: Recommendations

- Making a recommendation about an LST can be a very effective way to unite the patient's values and goals with treatment options.
- Ask permission before making a recommendation since some patients may prefer to let you know their thoughts.
- Recommend treatments that may help meet the patient's goals.
  - Focus on what can be achieved.
  - Focus on what might be possible.
  - Discuss what you will not do because it will not meet the goal.
- When making a recommendation, repeat the patient's goals using their own words.
- After making a recommendation, ask if it makes sense, given the patient's goals.
- For medical trainees and some clinicians, it may not be possible to immediately formulate a recommendation.
  - Elicit the patient's values and goals, inform your team what is important to the patient, and return with recommendations from the team.



### CAPTURES: Recommendations

- Would you like [me/our team] to make a recommendation about CPR based on what matters most to you and what [I/we] know about your health, or would you prefer to let me know your thoughts?

#### **If the patient has given you permission and you are able to make a recommendation:**

- Based on your goals to [state goals in patient's own words, e.g. "be at home, be able to care for yourself" etc.], I [would/would not] recommend CPR. Does that sound right to you?

#### **If you need assistance making a recommendation:**

- The information you shared with me about what matters most to you is very helpful. I'll share this with [our team/your doctors/etc.] and [I/we] will meet with you [X timeframe] to talk about a plan.

### CAPTURES: Empathize and Explore Challenges

- Remember these conversations can be very emotional.
  - We should attend to emotion BEFORE moving on to anything else.
  - Do not respond to feelings with facts — respond with empathy.
- If the patient needs more information or time to make decisions, explore what might help.
- Signs you need to explore include:
  - The patient's choices conflict with stated goals.
  - The patient is hesitant to make decisions.
- If a decision about LST appears inconsistent with the patient's goals, explore the reasons behind the decision and provide helpful responses:
  - Emotional responses → see page 7-8 in this guide for tips on responding with empathy.
  - Would like more information on CPR outcomes → see below and page 6 for information about CPR efficacy.
  - Other factors such as spiritual concerns → provide appropriate information or referral.

### Efficacy of CPR

- On average 17 out of 100 adults survive CPR to hospital discharge after an inpatient arrest. The survival rate is lower for outpatient arrests.<sup>1</sup>
  - Remember this number is an average; patients with certain health factors have a higher or lower chance of survival after CPR.
- Factors associated with failure to survive CPR to hospital discharge:<sup>2</sup>
  - Serum creatinine > 1.5mg/dl
  - Metastatic cancer
  - Dementia
  - Dependent status
  - Sepsis the day prior to the CPR event
- Also see <http://www.gofarcalc.com><sup>3</sup>



### CAPTURES: Empathize and Explore Challenges

#### Explore choices that conflict with goals:

- Tell me more about what you are hoping for with [X intervention].
- Is there a situation you could imagine when you [would /would not] want [X intervention]?
- Some find it helpful to know how many people with similar health problems survive after receiving CPR, or what the risks might be. What information would be helpful to you?

#### Explore hesitations to make decisions:

- Can you tell me what worries you about talking about CPR?

#### If the clinical situation is NON-URGENT and the patient does not want to discuss the topic after exploring their hesitations and worries:

- This topic deserves time and attention. We don't need to make decisions today. Let's set up a time to talk again when you are ready. In the meantime, here is some material that you may like to review.

#### If the clinical situation is URGENT and the patient does not want to discuss the topic after exploring their hesitations and worries:

- It is hard to talk about this and it's also very important so we understand your wishes. If you do not want to discuss this, would it be OK if we ask your [authorized surrogate] to help make decisions since we need to make decisions right away?

## Discussion Steps and Tips

CAPTURES: Empathize and Explore Challenges		
Data on CPR Survival and Neurological Outcomes for Inpatients Age > 65 Years <sup>4</sup>		
Discharge location	All who underwent CPR (n=42,566)	All who survived CPR (n=6,972)
Died	84%	Not applicable
Discharged home	6.2%	40%
Discharged inpatient facility	9%	55.2%
Discharged hospice	0.8%	4.8%
Cognitive status after CPR*	All who underwent CPR (n=42,566)	All who survived CPR (n=6,972)
Died	84%	Not applicable
Mild or no neuro disability	7.9%	48%
Moderate or severe neuro disability	8.1%	52%

\*Patients with good cognitive functioning prior to arrest had a lower risk of post-CPR cognitive disability (86% with good cognitive functioning on admission who survived CPR had good cognitive functioning upon discharge).<sup>5</sup>

### CAPTURES: Summarize the Plan

- To ensure shared understanding, summarize the plan and ask the patient to confirm.
- Repeat what the patient has just told you; this communicates that you have listened.
- Identify next steps.

## Words that Work

### CAPTURES: Empathize and Explore Challenges

#### If the patient would like information about CPR survival and risks:

- For people with health problems like yours, about [#] out of 100 survive when they receive CPR in the hospital. That means that [#] out of 100 people die. Survival is lower for CPR outside of the hospital.
- This can be surprising to hear.
- What is your understanding of some of the problems that can occur after CPR?
- There can be broken ribs. There are also risks of permanent brain damage and disability after CPR. Although a person's heart might restart, they may not be able to make decisions for themselves, recognize family, or return home. For people with health conditions like yours, the risk of having these problems is [low/high].



### CAPTURES: Summarize the Plan

- So it sounds like you [would/would not] want [X,Y,Z] [under A, B, C circumstance]. Do I have that right?
- I will put an order in your health record to make sure that staff knows what you want.
- Thank you for taking the time to have this important conversation with me.

### \*\*\*Examples of Empathic Responses\*\*\*

Naming	Understanding	Respecting	Supporting	Exploring	"I Wish"
This must be . . . <ul style="list-style-type: none"> <li>• Frustrating</li> <li>• Overwhelming</li> <li>• Scary</li> <li>• Difficult</li> <li>• Challenging</li> <li>• Hard</li> </ul>	What you just said really helps me understand the situation better.	I really admire your <ul style="list-style-type: none"> <li>• Faith</li> <li>• Strength</li> <li>• Commitment to your family</li> <li>• Thoughtfulness</li> <li>• Love for your family</li> </ul>	We will do our very best to make sure you have what you need.	Could you say more about what you mean when you say . . . <ul style="list-style-type: none"> <li>• I don't want to give up</li> <li>• I am hoping for a miracle</li> </ul>	I wish we had a treatment that would cure you [make your illness go away]. *[Remember we do have palliative treatments to offer the patient]
I'm wondering if you are feeling . . . <ul style="list-style-type: none"> <li>• Sad</li> <li>• Scared</li> <li>• Anxious</li> <li>• Nervous</li> <li>• Angry</li> </ul>	This really helps me better understand what you are thinking.	You (or your dad, mom, child, spouse) are/is such a strong person and have/has been through so much.	Our team is here to help you with this.	Help me understand more about . . .	I wish I had better news.
It sounds like you may be feeling . . .	I can see how important this is to you.	I can really see how [strong, dedicated, loving, caring, etc.] you are.	We will work hard to get you the support that you need.	Can you say more about that?	I wish the situation were different.
In this situation some people might feel . . .	Dealing with this illness has been such a big part of your life and taken so much energy.	You are such a [strong, caring, dedicated] person.	We are committed to help you in any way we can.	Tell me more about what [a miracle, fighting, not giving up, etc.] might look like for you?	I wish that for you too.  [In response to what a patient or family members wishes, such as a miracle]
I can see how dealing with this might be . . . <ul style="list-style-type: none"> <li>• Hard on you</li> <li>• Frustrating</li> <li>• Challenging</li> <li>• Scary</li> </ul>		I'm really impressed by all that you've done to manage your illness [help your loved one deal with their illness].	We will be here for you.		I wish we weren't in this spot right now.

### \*\*\*Responses to Challenging Questions Using Empathic Statements\*\*\*

#### God's going to bring me a miracle:

- I hope that for you too. (**Remember - no buts!**) (**SUPPORTING**)
- I really admire and respect your faith. (**RESPECTING**)
- Having faith is very important. (**RESPECTING**)
- Can you share with me what a miracle might look like for you? (**EXPLORING**)

#### Are you telling me my dad is dying?

*NOTE: These responses will affirm the question empathically – so do not use them if the patient is not dying.*

- I wish I had better news.
- This must be such a shock for you. (**NAMING**)
- I can't even imagine how difficult this must be. (**UNDERSTANDING**)

#### Are you saying there is nothing more you can do?

- It sounds like you might be feeling ... (**NAMING/EXPLORING**)
  - Alone
  - Scared
  - Frustrated
  - Etc.
- I wish we had a treatment that would cure you. Our team is here to help you through this. (**Remember - no buts!**) (**SUPPORTING**)
- I can't even imagine how (**NAME EMOTION**) this must be. (**NAMING**)

#### How much time do I have left?

*NOTE: This question may mean many things – they are scared, they want to know so they can plan, they are suffering, etc. Exploring what they want to know can be very helpful.*

- That is a great question. I am going to answer it the best that I can. Can you tell me what you are worried about? (**EXPLORING**)
- That is a great question. I am going to answer it the best that I can. Can you tell me what information would be most helpful to you? (**EXPLORING**)

#### Are you giving up on me?

- I wish we had more curative treatments to offer. Our team is committed to help you in every way we can. (**Remember - no buts!**) (**SUPPORTING**)
- We will be here for you. (**SUPPORTING**)
- It sounds like you might be feeling ... (**NAMING/EXPLORING**)
  - Alone
  - Scared
  - Etc.
- We will work hard to get you the support that you need. (**SUPPORTING**)

#### My dad is a fighter!

- He is. He is such a strong person and he has been through so much. (**Remember - no buts!**) (**RESPECTING**)
- I admire that so much about him. (**RESPECTING**)
- I really admire how much you care about your dad. (**RESPECTING**)
- It must be (**NAME EMOTION**) to see him so sick. (**NAMING**)
- Tell me more about your dad and what matters most to him. (**EXPLORING**)

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### Sources

- Goals of Care Conversations Training, Department of Veterans Affairs. <http://www.ethics.va.gov/goalsofcaretraining.asp>
- Palliative Care Fast Facts and Concepts (originally published by the End-of-Life/Palliative Education Resource Center, Medical College of Wisconsin), Palliative Care Network of Wisconsin <http://www.mypcnow.org/#!/fast-facts/c6xb>
- VitalTalk, <http://www.vitaltalk.org>
- POLST. Retrieved from: <http://www.polst.org/about-the-national-polst-paradigm/what-is-polst/>

### References

<sup>1</sup> Saket, et al. Trends in Survival after In-Hospital Cardiac Arrest. N Engl J Med 2012; 367:1912-1920.

<sup>2</sup> Ebell MH, et al. Survival after in-hospital cardiopulmonary resuscitation: a meta-analysis. J Gen Int Med. 1998; 13(12):805-16.

<sup>3</sup> Ebell MH, et al. Development and Validation of the Good Outcome Following Attempted Resuscitation (GO-FAR) Score to Predict Neurologically Intact Survival After In-Hospital Cardiopulmonary Resuscitation. JAMA Intern Med. 2013;173(20):1872-1878.

<sup>4</sup> Chan, et al. Long-Term Outcomes in Elderly Survivors of In-Hospital Cardiac Arrest. N Engl J Med 2013; 368:1019-26.

<sup>5</sup> Peberdy, et al. Cardiopulmonary resuscitation of adults in the hospital: A report of 14,720 cardiac arrests from the National Registry of Cardiopulmonary Resuscitation. Resuscitation. 2003; 58 297-308.

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