

Lycoming County POLST Project

Williamsport, PA
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"Home of the Little League"

Williamsport 30,000
"Greater Williamsport area" 70,000
Lycoming County 120,000

Susquehanna Health
Williamsport Hospital (WRMC) 175 beds
Muncy Valley Hospital 25 bed CAH
Jersey Shore Hospital 25 bed CAH

Regional POLST/ACP Project

Initiative of WRMC ethics committee:2005
Three hospitals
Eight skilled nursing facilities with total 1100 beds
Clinical, administrative representation from each organization
Worked to develop a commonly acceptable POLST form

Is the Document Enough?

The POLST form is an essential element of a system to document and transmit patient care preferences, but it is not the MAIN thing.

Careful discussions that elicit care preferences ARE the main thing.

Who will facilitate these discussions ?

Physicians/Providers-the only ones to lead these discussions?

Need for non-physician facilitators to lead patient/family discussions, elicit preferences and complete POLST forms

Facilitators need to be skilled, knowledgeable, and credible to physicians/providers as well as to patients and families

Facilitator training

Respecting Choices curriculum (Gunderson/Lutheran Health system, Lacrosse Wisconsin)

Fundraising from regional funding sources for training process.

Four training sessions; 2006, 2008,2009,2011
144 facilitators trained, two thirds from hospitals and skilled nursing facilities

North Central Pennsylvania Advance Care Planning Task Force

Community focus- "Pink Card"-encourage all to consider and name an agent, document their choice on portable card, and TALK to their agent about their preferences.

Facility focus-POLST training, 4 hour session including information about ACP issues, important medical and ethical information, detailed review of Pennsylvania POLST form, and observed role playing facilitation

Lessons learned

Training facilitators is critical

Not just cognitive, informational teaching
Inclusion of experiential, interactive experience
Observed role-playing of facilitation discussions
Established published curriculum, or curriculum developed locally

Don't try to do too much initially

Early focus on community based advance care planning, including ACP for all ages/stages.
Start with most pressing patient types (elders in SNU, those "you wouldn't be surprised if they died within a year")
Expand into community as secondary or separate initiative

Don't try to do too much initially

Instead of including all SNU's/regional hospitals in one large cooperative project, select specific "partner" facilities and grow out. Idea of "fertile soil", "primed facilities"-build upon success incrementally.
Change the acceptable "norm" gradually

Challenges to change in medical institutions

SNU-buy in clinical/administrative/corporate
Physician buy in, importance of credible facilitators and process, with physicians/providers ultimately responsible for the POLST order they sign.

Limits of the form

Naming of agent (separate and essential document)
Need to clarify and write in preferences regarding hospitalization for those who want more than comfort care but not full treatment
Limit of its use outside of institution (home hospice, transport, ALF)- importance of EMS "work around", and of out of hospital DNR forms.

Moving away from emphasis on completion of POLST as individualistic, rights-based, legal process...instead approaching this process as a means for the family, nurses, doctors to understand and honor what the patient wants, to understand and do 'the right thing' for the patient.

Emphasis on relationship(with loved ones and those providing care for the patient) vs policy, legal responsibilities

Our patients/families are counting on us

We and our loved ones are going to age, get sick and die in the medical system of care that we create

A motivated group can make even major changes happen over time

In your world, if you don't change things, who will?

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