Advance Care Planning and Palliative Care in the World of Health Reform

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AGENDA

1. Welcome and Introductions
    a) Stuart Levine, MD, MHA - Medical Director, HealthCare Partners, Torrance, CA

2. Advanced Care Planning: The Big Picture
    a) Stuart Levine, MD, MHA - Medical Director, HealthCare Partners, Torrance, CA Asst. Professor- Internal Medicine/ Psychiatry, UCLA David Geffen School of Medicine

3. Case Study: Best Practices at HealthCare Partners
    a) Susan Stone, MD, Regional Lead Palliative Care and Advanced Care Planning, HealthCare Partners, Torrance, CA
    b) Sayeed Khan, MD, Regional Lead Hospitalist and High Risk Program Medical Director, HealthCare Partners, Torrance, CA
    c) Karol Attaway, MHA, Vice President of Operations, HealthCare Partners, Los Angeles, CA

4. Case Study: Sharp Reese-Stealy- A Best Practice at Leading California Organizations
    a) Jerry Penso, MD, MBA, Continuum of Care, Sharp Rees-Stealy, San Diego, CA

The Age of Medical Miracles

It's Not All Miracles: Health States People May Not Want

- **Permanent vegetative state (PVS)**
- **Minimally conscious state**
- **Incapable of recognizing others**
- **Incapable of breathing on own**
- **Incapable of caring for self**

Health Reform and Advance Care Planning

- **House of Representatives Bill 3200 (2009):**
- **Reimburse physicians for counseling Medicare patients about:**
  - **living wills**
  - **advance directives**
  - **other end of life issues**

Death Panels

"The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama's "death panel" so his bureaucrats can decide, based on a subjective judgment of their "level of productivity in society," whether they are worthy of health care.

- former Alaska Governor Sarah Palin
  Facebook, August 7, 2009

Death Panels

“Lie of the Year”

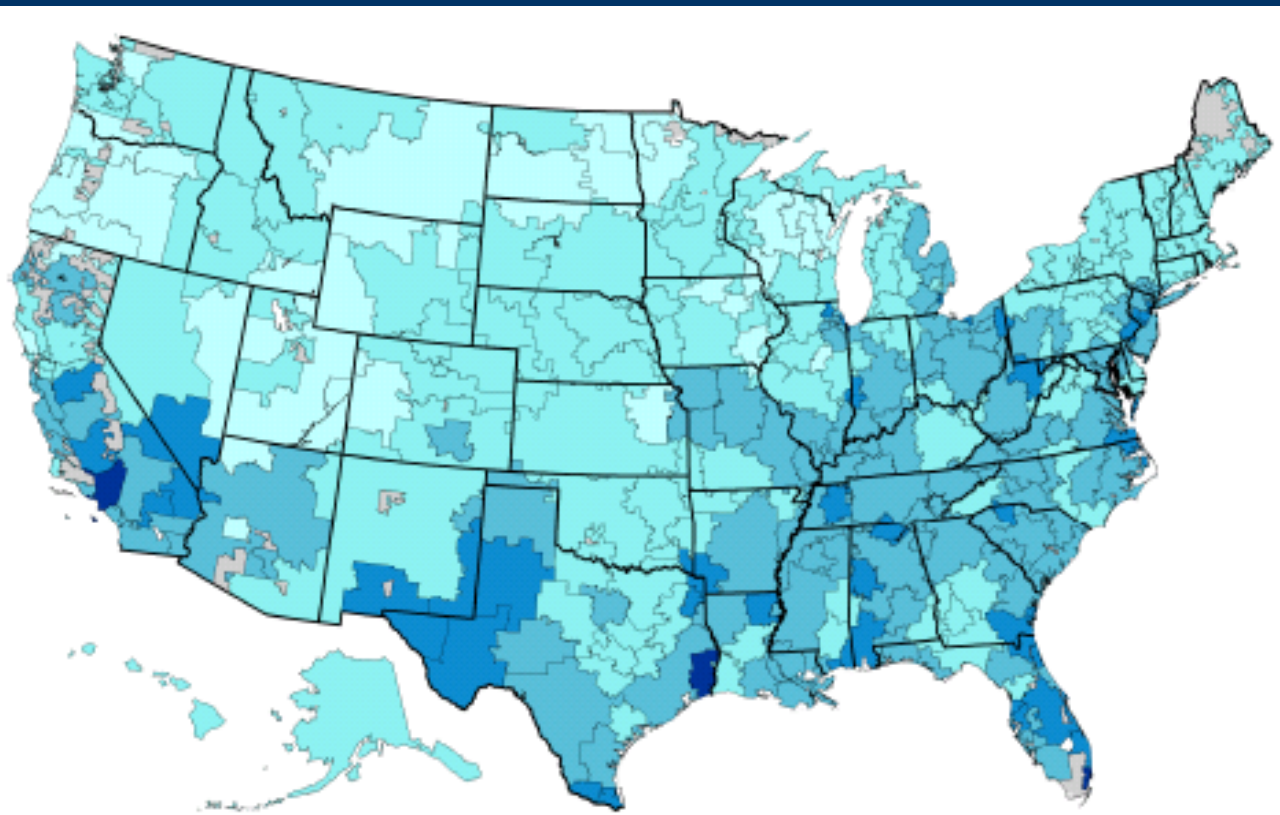
-Politifact.com

“One of the whoppers of 2009”

-Factcheck.org

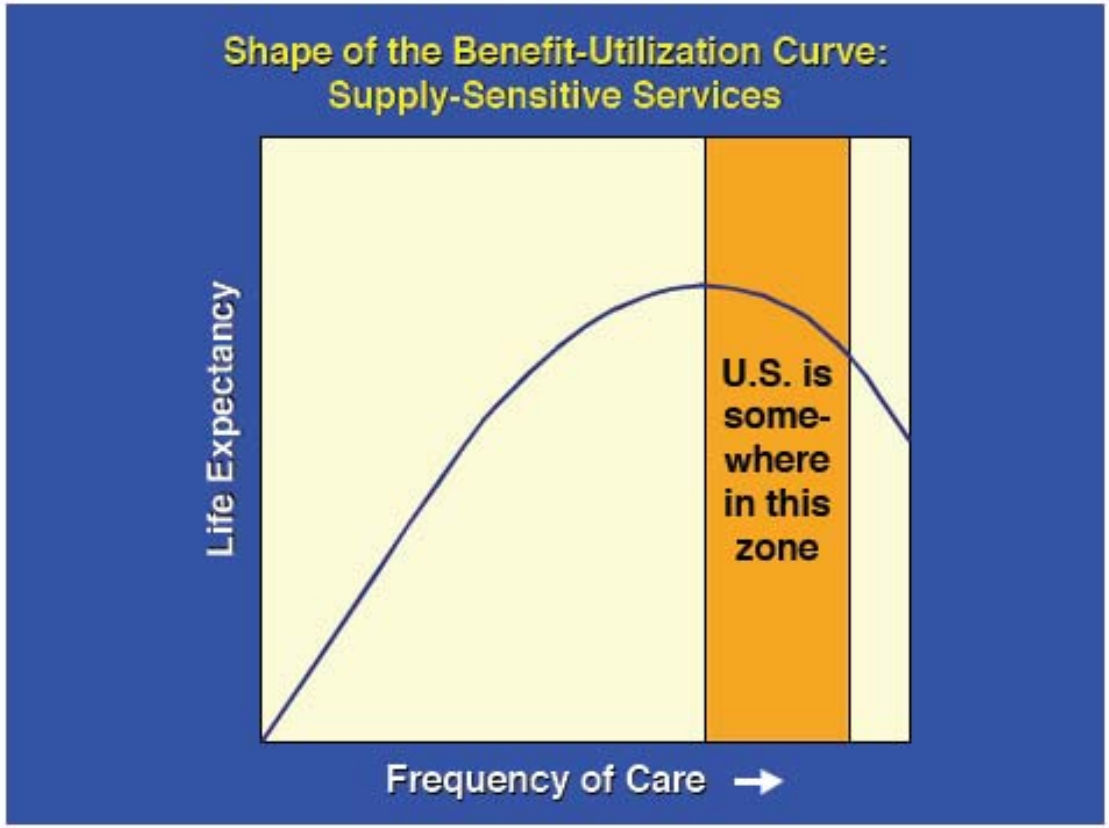
“most outrageous” word for 2009

-American Dialect Society

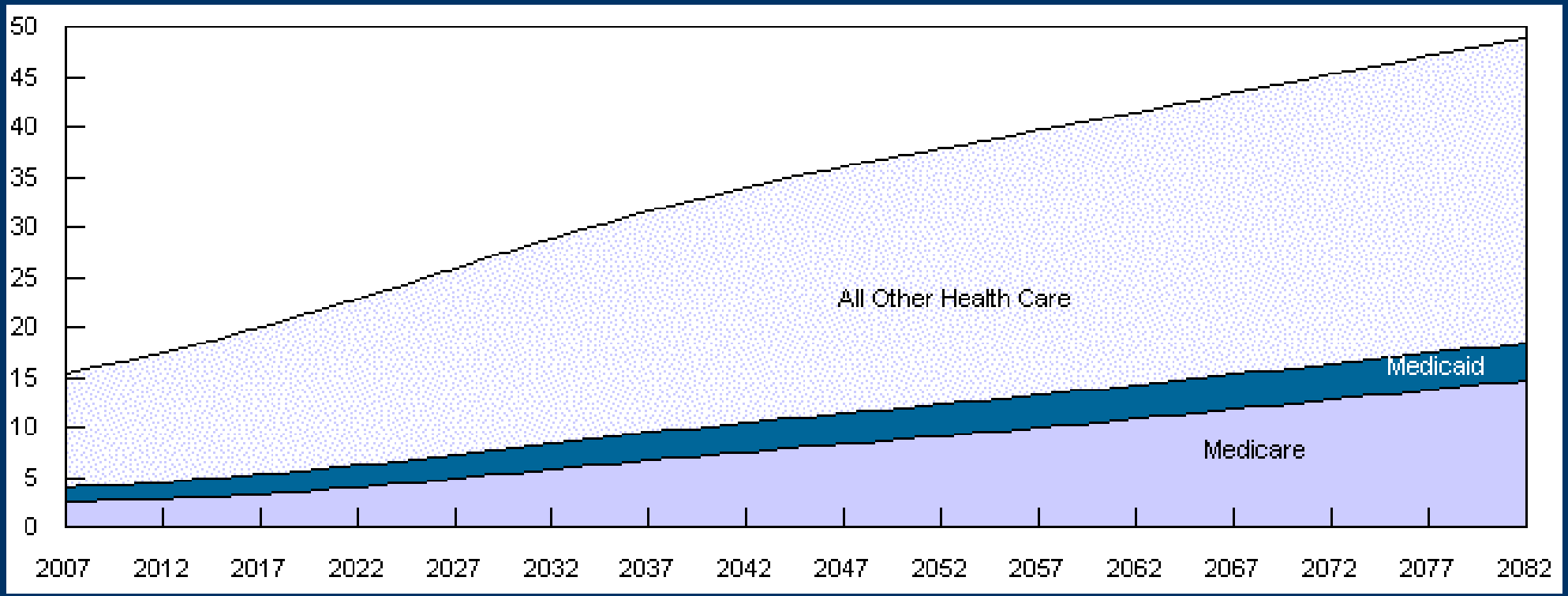


Map 6.3. Percent of Medicare Enrollees Who Spent Seven or More Days in Intensive Care During Their Last Six Months of Life (1995-96)

The likelihood of spending at least one week of the last six months of life in intensive care was higher among enrollees in the East, Midwest, Texas and southern California. Medicare residents of the Upper Midwest, Mountain states, and Oregon were on average less likely to spend seven or more days in intensive care at the end of life.


Shape of the Benefit-Utilization Curve:
Supply-Sensitive Services
Life Expectancy
U.S. is some-where in this zone
Frequency of Care

Projected Health Care Spending as % of GDP



-Congressional Budget Office. Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

Case 1: Bridge to transplant

- **A 55 year old woman had a massive heart attack. She was stabilized but developed renal and respiratory failure. Airlifted to a quaternary care medical center for possible heart transplant.**
- **Despite the low chance of success, a ventricular assist device is implanted as a *bridge* to heart transplant. However, she develops infection and complications so she is no longer and will never be a transplant candidate.**
- **Her family refuses to stop the ventricular assist device.**

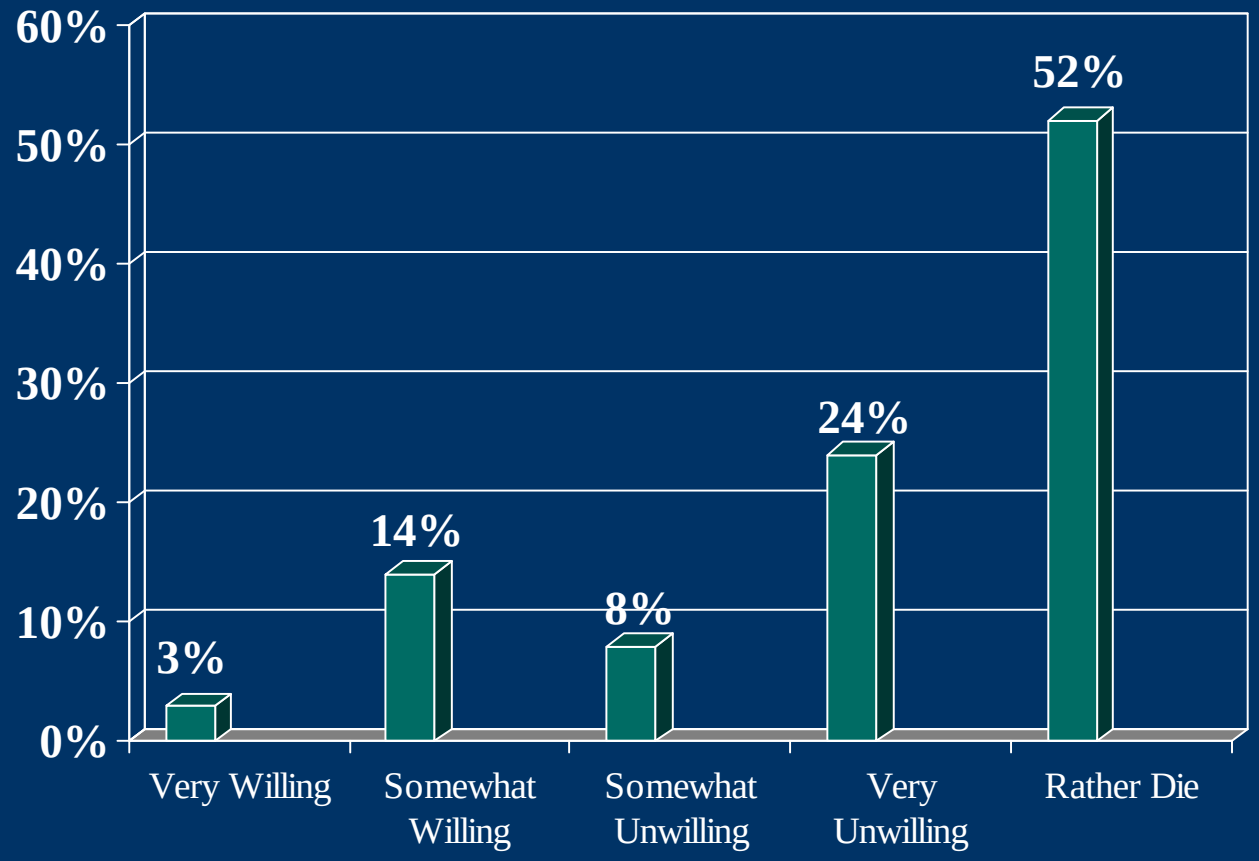
The Goals of the Healthcare System

- **Restoration of health, saving of life**
- **Restoration or preservation of function**
- **Relief of symptoms, provision of comfort**
- ***Steward scarce healthcare resources?***

Case #2: Aspiration Pneumonia

- **A 75 yo woman with advanced dementia is admitted to the hospital from home with an aspiration pneumonia. Due to worsening function, the patient can no longer be cared for at home.**
- **The family and clinicians decide to place a G-tube prior to NH transfer.**

Willingness to Live Permanently Fed Through a Tube



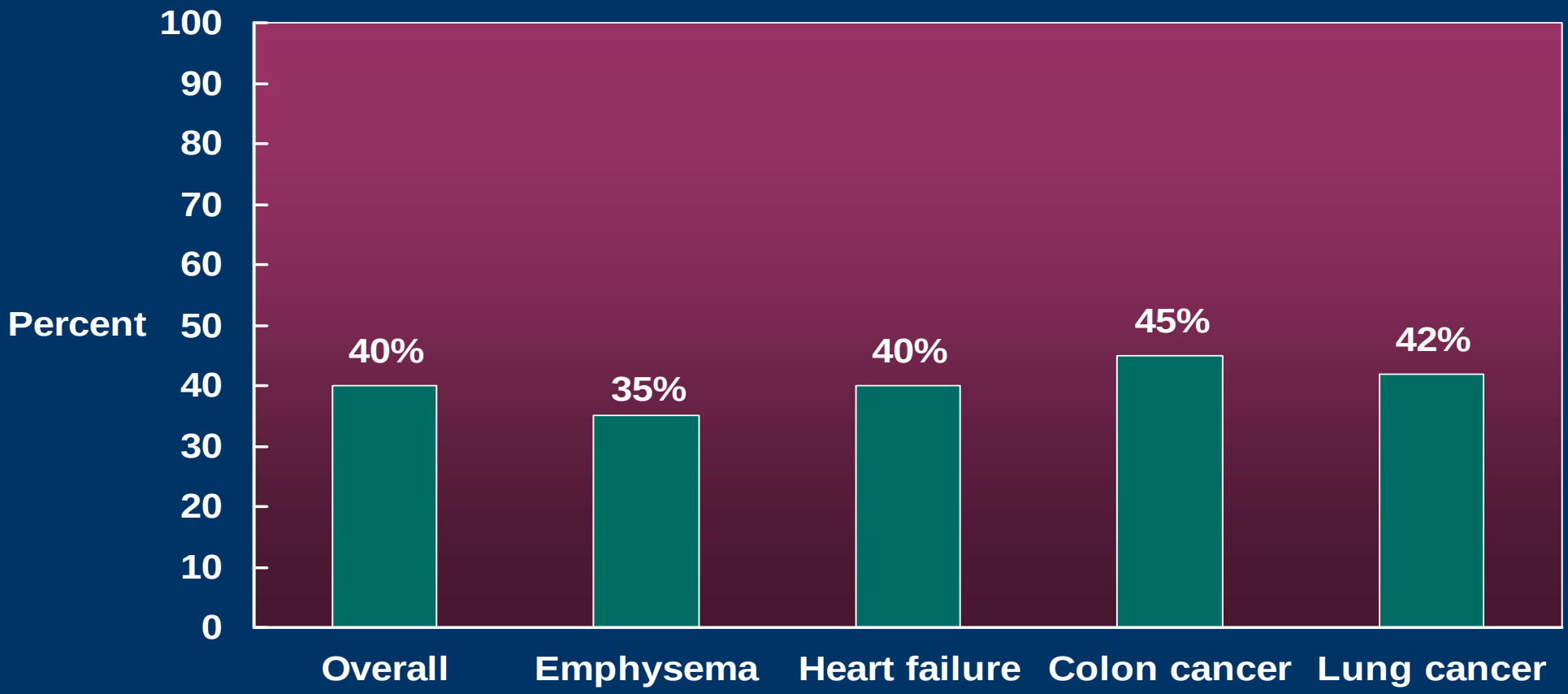
-SUPPORT study data (N=3828)

Quality of Care at the End of life

Inadequate emotional support	**50%**
Not enough information	**30%**
Inadequate physician communication	**24%**
Inadequate attention to pain	**24%**
Inadequate attention to dyspnea	**22%**

-Teno JM, et al. Family perspectives on end-of-life care at the last place of care. JAMA. 2004;291:88-93.

Pain Before Death in the Hospital



-Lynn, Teno, Phillips, et al. Perceptions by family members of the dying experience. *Ann Intern Med.* 1997;126:97-106.

Case #3: Heart failure

- **A 71 yo man with ischemic cardiac disease gradually developed severe systolic heart failure (EF<20%) over the past 4 years.**
- **No CAD lesions amenable to bypass or stent, cardiologist has maximized medical therapy and his renal function is now worsening.**
- **Asked to complete a Five Wishes, but he never returned it.**
- **Presents to an ER with pneumonia and pulmonary edema. A week later he is intubated in the ICU in multiple organ system failure.**

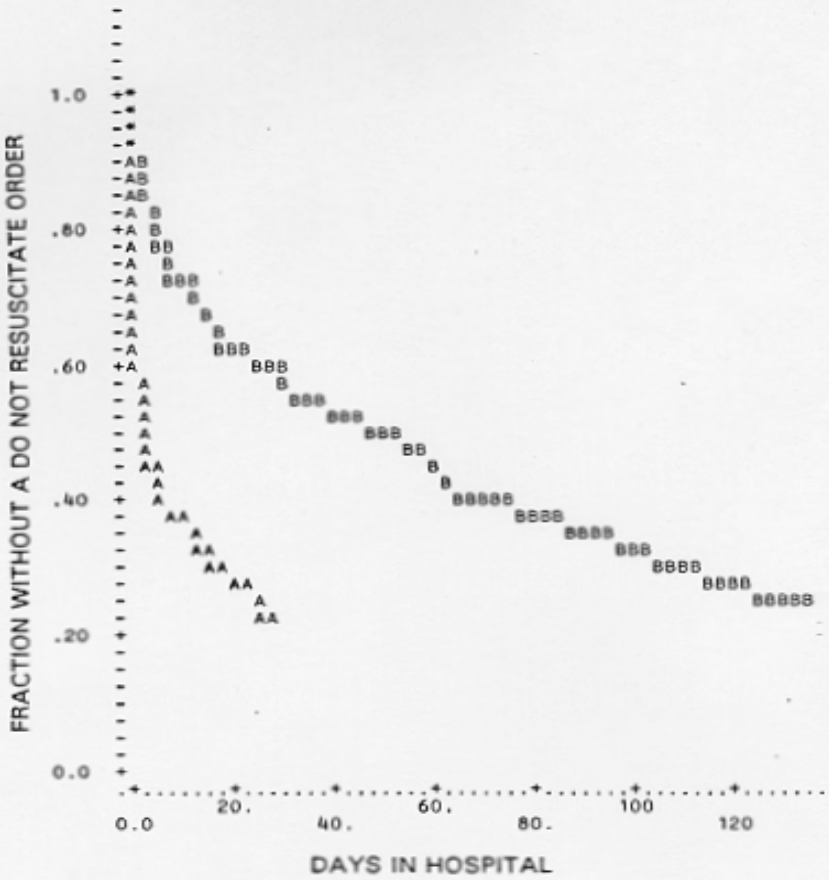
Obstacles to Advance Care Planning

- **Not enough time**
  - **Other pressing issues**
- **Uncomfortable conversation**
  - **For patient/family**
  - **For clinician**
- **Someone else's responsibility**
- **Not the right time**
  - **This can happen later when the issue arises**

Physician Understanding of Patient Preferences about Resuscitation

		Patient	
		Receive CPR	**Forgo DNR**
Physician	**Receive CPR**	**2783**	**990**
	Forgo DNR	**455**	**827**

-*J Am Geriatr Soc*. 2000;48(5 Suppl):S44-51.



Time in hospital before receiving a do not resuscitate (DNR) order among patients who prefer to be DNR. Patients (n = 334) whose physicians understood their preference to be DNR (indicated by AAA) received DNR orders earlier than patients (n = 416) whose physicians misunderstood their preference to be DNR (indicated by BBB). Patients with a DNR order prior to study entry are excluded.

Stability of No CPR Orders Across Hospital Admissions

- **543 patients hospitalized with a DNR order and then readmitted to the same hospital:**
- **157 (29%) did not have a DNR order during the subsequent admission**
  - **For 62% of these patients, no documentation about CPR during the subsequent admission.**

-J Clin Ethics. 1996;7:48-54.

Continuity of Advance Care Planning Documentation between Hospital and Outpatient Settings

	Hospital				
Outpatient Setting	AD or Pref note	Seeking note	"Full Code"	None	Total
AD or Preference note	4	0	0	2	6
Seeking note	0	4	0	2	6
"Full Code"	0	1	0	0	1
None	8	13	4	3	28
Total	12	18	4	7	41

-Yung VY, Walling AM, Min L, et al. Documentation of advance care planning for community-dwelling elders. J Palliat Med. 2010;13:861-7.

Advance Care Planning: Theory

- **Patients have the right to direct care**
  - ***within the goals of Medicine***
- **Physicians have a beneficent duty to tailor care to a patient's clinical circumstances and preferences**
  - ***and steward resources***
- **This may require:**
  - **specification of a surrogate**
  - **prospective discussion of care goals**
    - **documentation to inform care**

Case 4: The Case of Mr. K.

- 68 yo M with end-stage liver disease is admitted to the hospital with an upper GI bleed
- Over 1 week, the bleeding stabilizes, but his liver failure worsens; he develops an infection
- After 1 month in the hospital, the infection continues and he is put on a ventilator because of respiratory failure; he has recurrent UGI bleeding

The Case of Mr. K. (continued)

- After 1 month in ICU (2 in the hospital), Mr. K's liver is so bad that only a liver transplant will save him
- The infection must clear to get a transplant; the doctors think this is unlikely to happen, yet this is not conveyed to the family
- 3 months in the hospital: family feel that the patient is uncomfortable. Mr. K becomes sicker and requires medications to support his blood pressure
- In the setting of hypotension, Mr. K suffers cardiac arrest and is resuscitated. His chance of receiving a transplant is now tiny, but there's no discussion about it

The Case of Mr. K. (conclusion)

- **After 4 months in the hospital, 3 in the ICU, Mr. K begins actively to die; family is told that he will not receive a liver transplant**
- **He is made comfortable and dies within 24 hours**

Challenges with This Case

- **Prognostication is difficult**
  - **Physicians may be overly optimistic**
- **The patient is not making the decisions**
- **Clinical status is not updated to refocus goals**
- **We have capability to maintain those barely alive**
- **Symptoms are often untreated**

Study of How Patients Die in the Hospital

- **Initiation of aggressive therapies**
- **Withdrawal of aggressive therapies**
- **Whether death was expected**
- **Patient and family centered care**
- **Whether patients receive care contained in quality indicators**

-Walling A et al. The Quality of Care Provided to Hospitalized Patients at the End of Life. Arch Intern Med. 2010;170:1057-63.

Quality Measures for End-of-Life Care

- ACOVE (Assessing Care of Vulnerable Elders): quality measures for elderly at risk of death or disability within two years
- ACOVE contains 392 evidence-based process measures
  - 26 conditions
  - Prevention – Diagnosis – Treatment - Follow-up
  - 16 applicable to a terminal hospitalization
- Key domains: pain, shortness of breath, goals of care

Testing the Process-Outcome Link: Relationship of Quality and Survival

3 year survival for 10 equal interval of quality score

What Does a Pain Quality Indicator Look Like?

- **IF a vulnerable elder has a new moderate or severe pain complaint…**
- **THEN the medical record should indicate that an intervention for the pain occurred within 4 hours**

  - **Timely intervention and reassessment of pain**
  - **Assessment during the last 7 days**
  - **Bowel preparation for chronic opiate therapy**

What Does a Goals-of-Care Quality Indicator Look Like?

- **IF a vulnerable elder is admitted to the ICU and survives 48 hours,**
- **THEN within that time, the medical record should document that patient preferences for care have been considered or an attempt was made to identify them**
  - **Proxy decisionmakers**
  - **Goals considered for permanent feeding tube**
  - **Patient participation (preferences guide decisions)**
  - **Deactivate implantable cardioverter defibrillator (ICD) if death expected**

Data Sources

- All inpatient adult deaths 4/05 - 3/06 at UCLA Medical Center
  - Length of stay > 3 days
- Abstracted full set of inpatient medical records
  - Written record
  - Electronic record
  - Nursing electronic database

Results: UCLA Sample's Characteristics (N=496)

Age, mean	**62 years**
Female	**47%**
Married	**60%**
Advanced cancer	**21%**
End stage lung disease	**11%**
End stage liver disease	**16%**
Transplant considered	**25%**

Results: Insurance

Primary Health Insurance	
Medicare	29%
Private	45%
Medi-Cal	9%
Dual eligible	12%
Uninsured/Self-pay/Other	5%

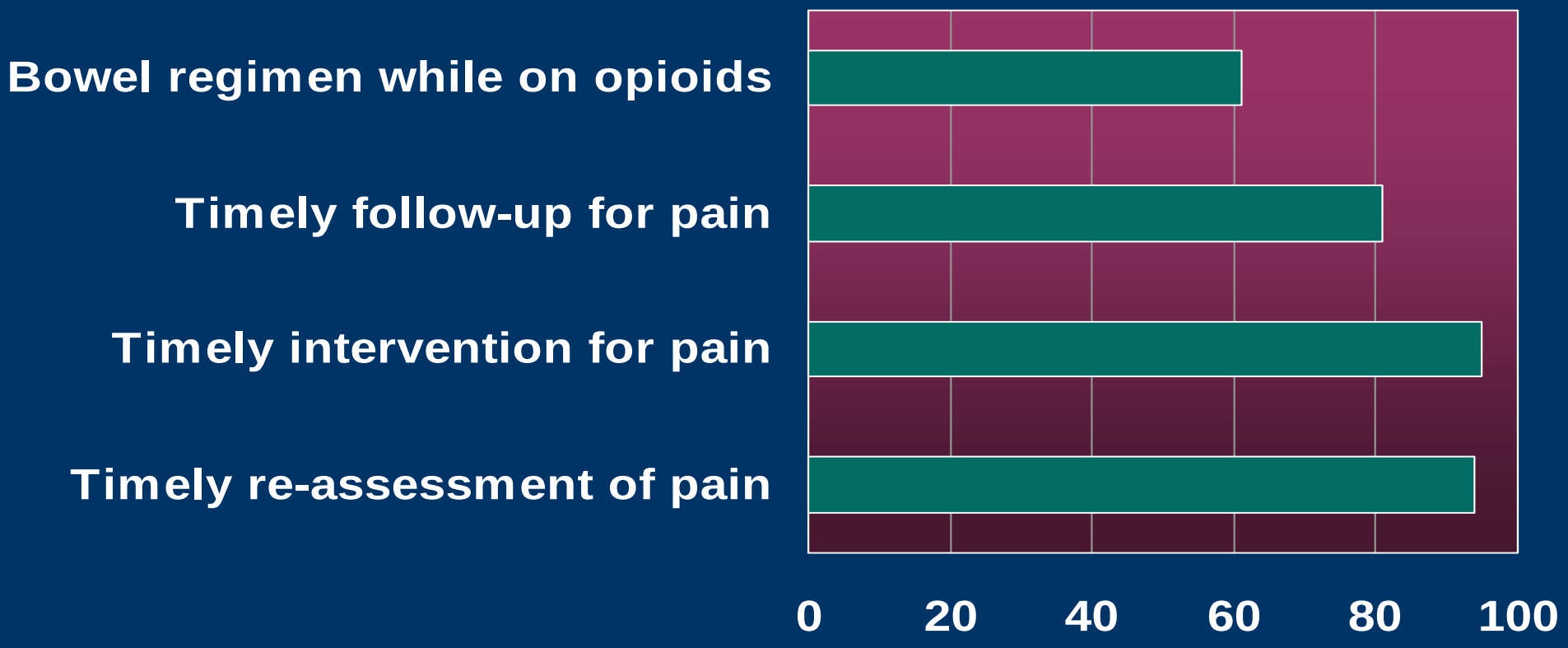
Results: Aggressive Treatments Started and Stopped for Patients Dying in the Hospital

ICU Care	**82%**
Length of ICU stay	**18 days (range 1-194)**
Ventilator started	**72%**
Ventilator withdrawn	**33%**
Hemodialysis started	**33%**
Hemodialysis withdrawn	**12%**
Died receiving CPR	**15%**
Death was expected	**85%**

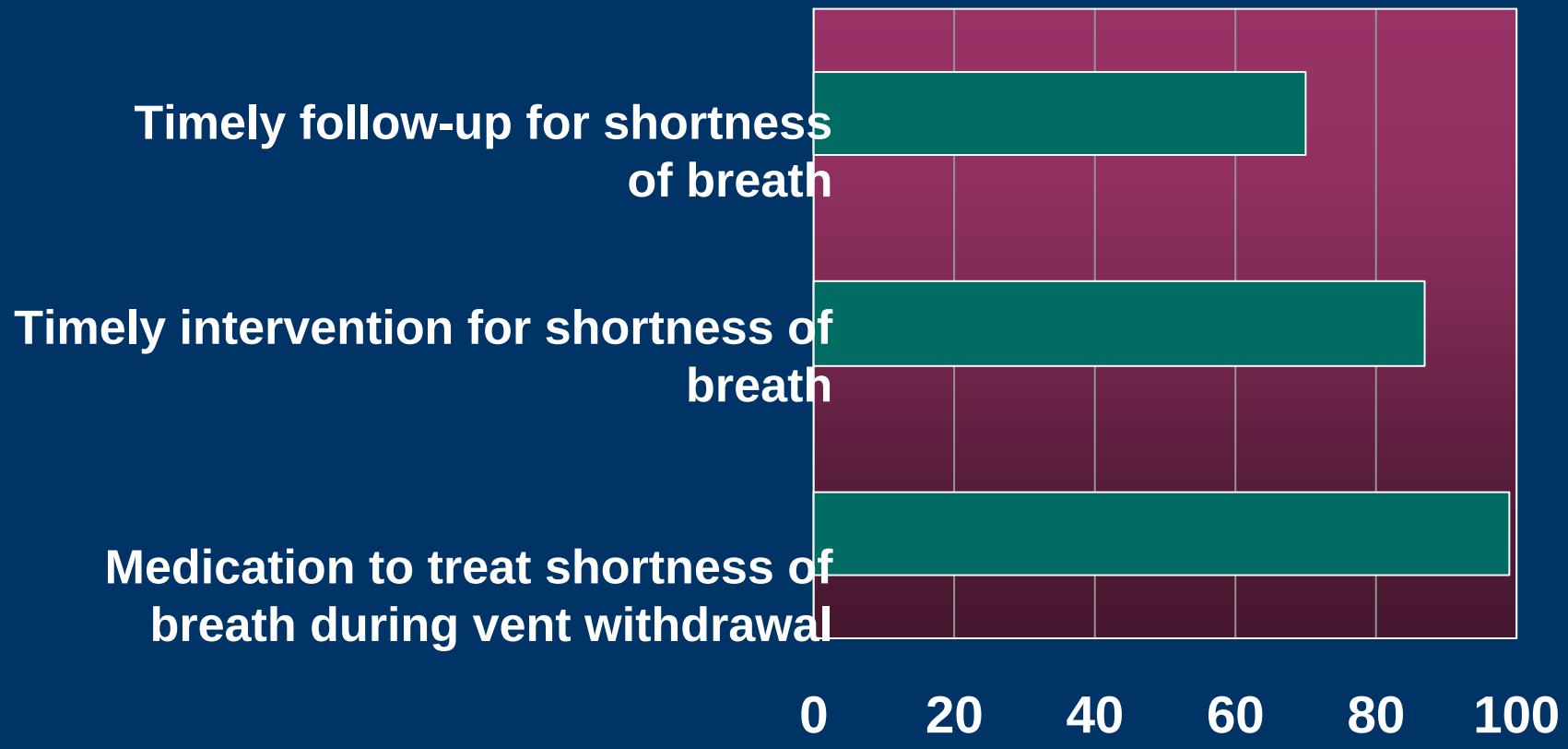
Quality of Care for Patients Dying in the Hospital was High

- **Overall quality = 70%**
- **Patients eligible for mean of 6.2 quality indicators**
- **17% of patients received 90% or more of quality indicator care**

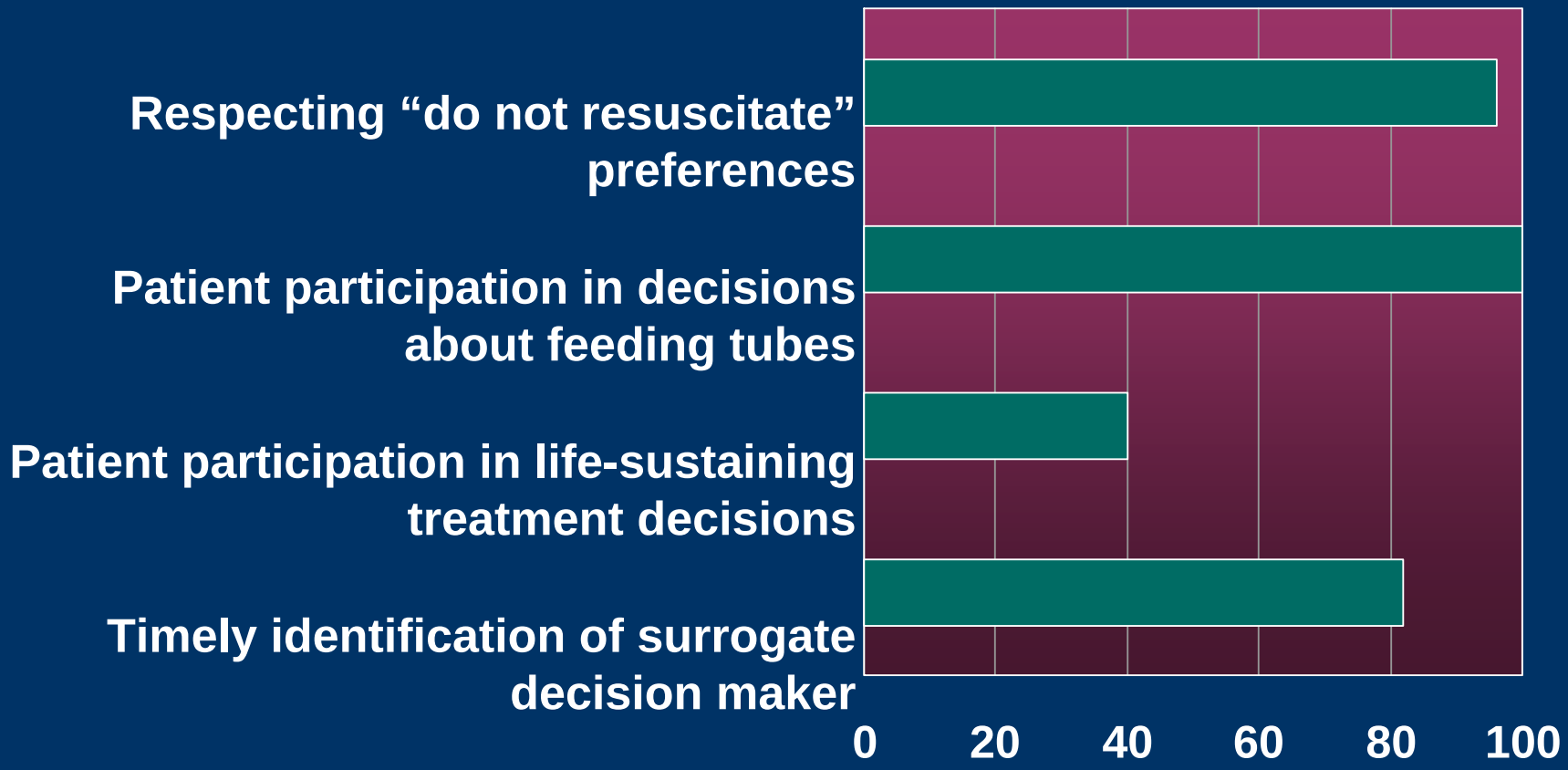
Quality of Pain Care Was Relatively High



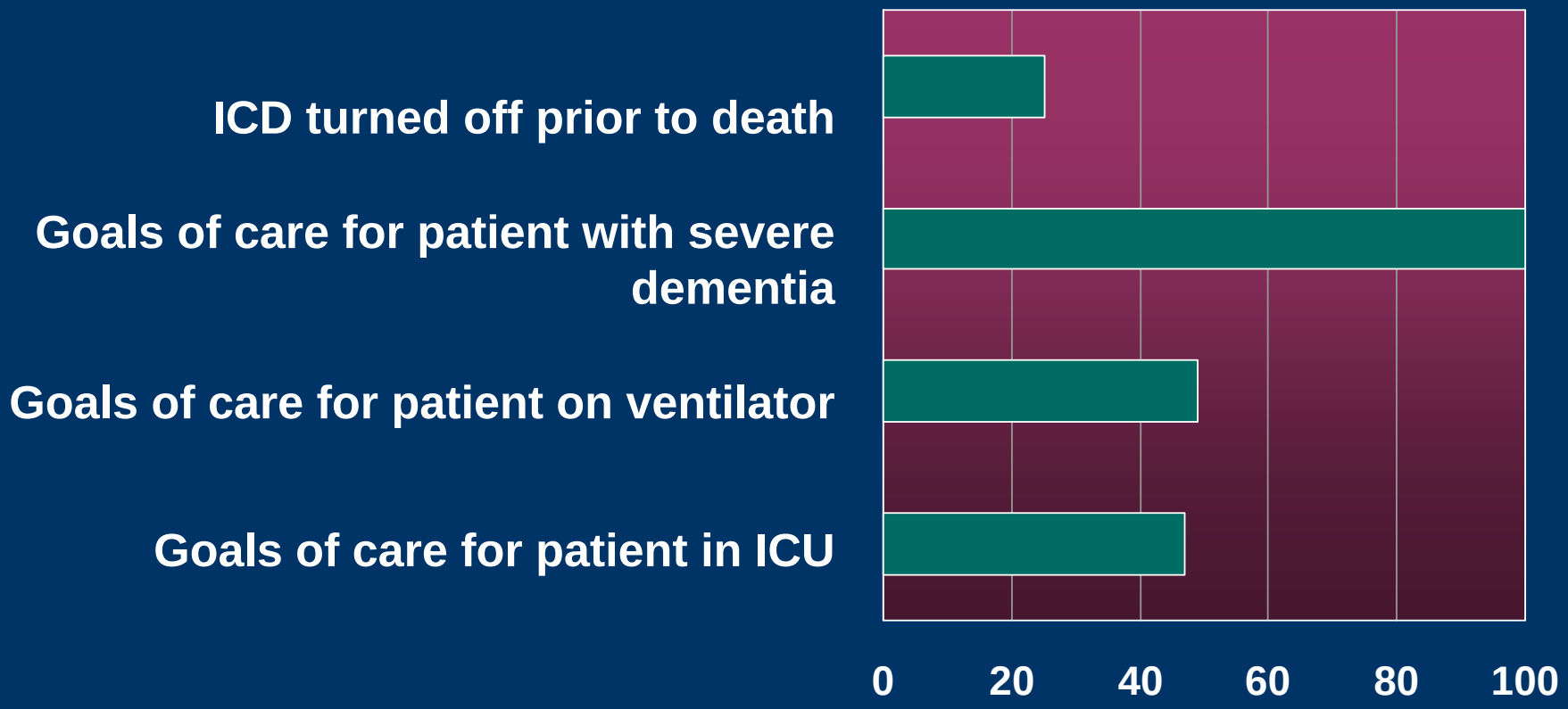
Shortness-of-Breath Care Quality Showed More Variation



Quality of Goals of Care: Variable to Low



Quality of Goals of Care: Variable to Low



Summary

- Patients receive aggressive care before death. For majority of patients, treatments must be withdrawn or withheld to allow death
- Inadequate emphasis on the communication process needed for timely and holistic treatment decisions

How Could We Improve Care for Mr. K.?

- Mr. K, a 68-year-old man with end-stage liver disease is admitted to the hospital with UGI bleeding
- An iterative discussion of treatment options that reflected changes in clinical status and prognosis could lead to care planning
- Combine palliation with aggressive care and then modulate these as clinical status changes

How Could We Improve Care for Mr. K.? (Cont.)

- 6 weeks in ICU, prognosis worse
  - Conversation about diminishing chance of transplant
  - Palliation added to life-sustaining treatment
- Ongoing discussion with family and patient leads to decision to pursue comfort care because prognosis diminishing
- Comfortable death, earlier, outside of ICU

Advance Care Planning: Practice

- **The right conversation at the right time**
  - **Surrogate specification**
  - **Completion of an advance directive**
  - **Completion of additional materials**
    - **Five Wishes**
    - **POLST**

Most important is to have initiated the Advance Care Planning conversation

Case #5: The Landlord

- **An 82 yo generally healthy man with hypertension and OA presents to establish care with a new PCP.**
- **During the history, the physician finds out that the patient has no living family and no real friends.**

Doc: So, who would make medical decisions for you if you can't make them yourself?

Patient: Oh, my landlord. He knows exactly what I would want.

Advance Care Planning: Practice - 2

- **Surrogate decision maker should be identified for all older patients**
- **Particular patients should be targeted for ACP:**
  - **No family or family members lack decision making capacity**
  - **Likely disagreements among potential surrogates**
  - **Surrogate likely to make different decisions than patient**

Factors Associated with Deteriorated Function post-CPR

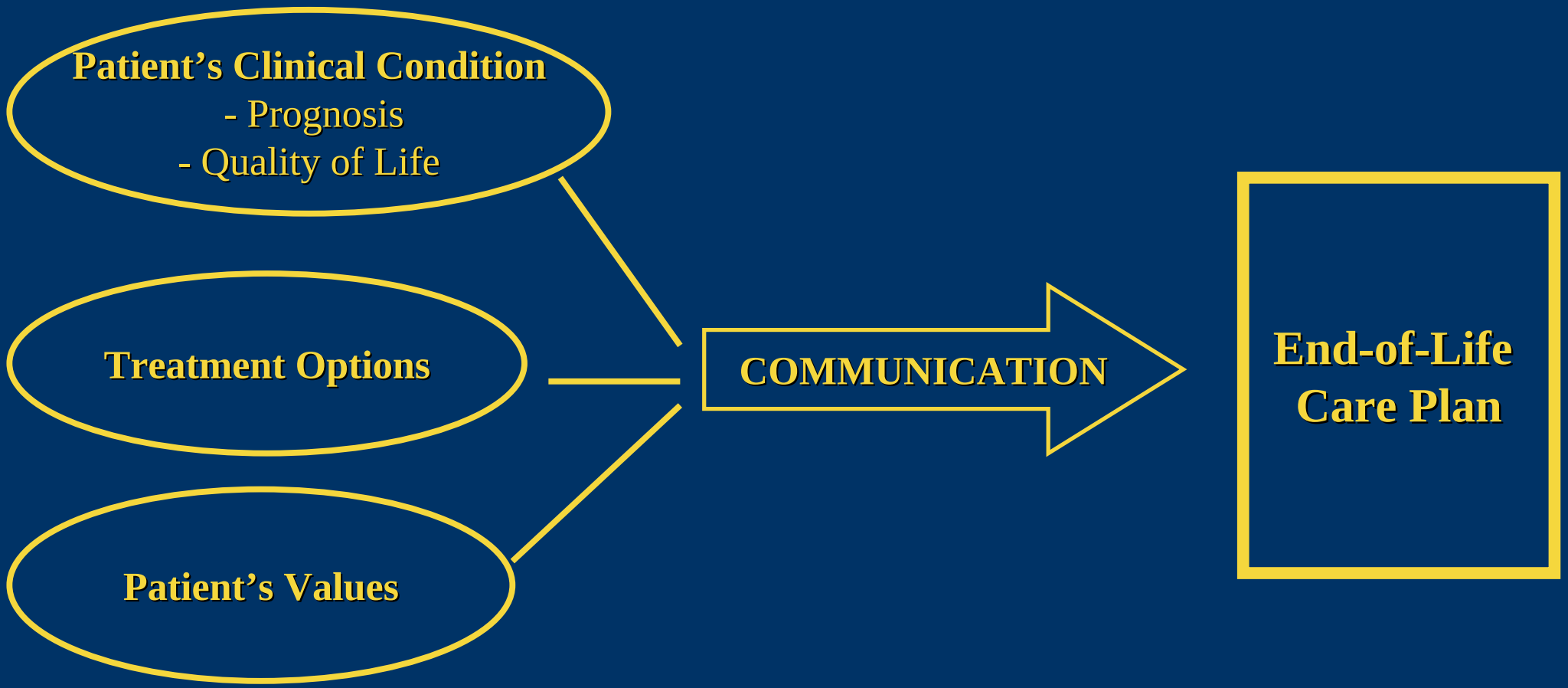
	Odds Ratio (95% CI)
Age <55 years	1.00
56 - 65 years	1.13 (0.33, 3.89)
66 - 75 years	1.21 (0.38, 3.86)
>75 years	5.25 (1.45, 19.1)
Acute physiology score (per point)	1.02 (1.00, 1.05)
CPR hosp day >4	8.30 (3.14, 23.3)

-FitzGerald et al. *Arch Intern Med*. 1997;157:72-6.

Advance Care Planning: Practice - 3

- **In-depth consideration of goals and values**
  - **Advanced disease**
  - **High-risk procedures**
- **Consider discussing with patient:**
  - **Five Wishes**
  - **Willingness to tolerate health states**
- **Specification of treatment preferences**
  - **POLST**

What Guides Care at the End of Life?



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2009)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A — CARDIOPULMONARY RESUSCITATION (CPR): *Person has no pulse and is not breathing.*

Check One

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

(Section B: Full Treatment required)

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B — MEDICAL INTERVENTIONS: *Person has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. ***Transfer** if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Do Not Transfer to hospital for medical interventions. Transfer*** if comfort needs cannot be met in current location.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer** to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D — SIGNATURES AND SUMMARY OF MEDICAL CONDITION:

Discussed with:

☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other:

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Decisionmaker, Parent of Minor or Conservator

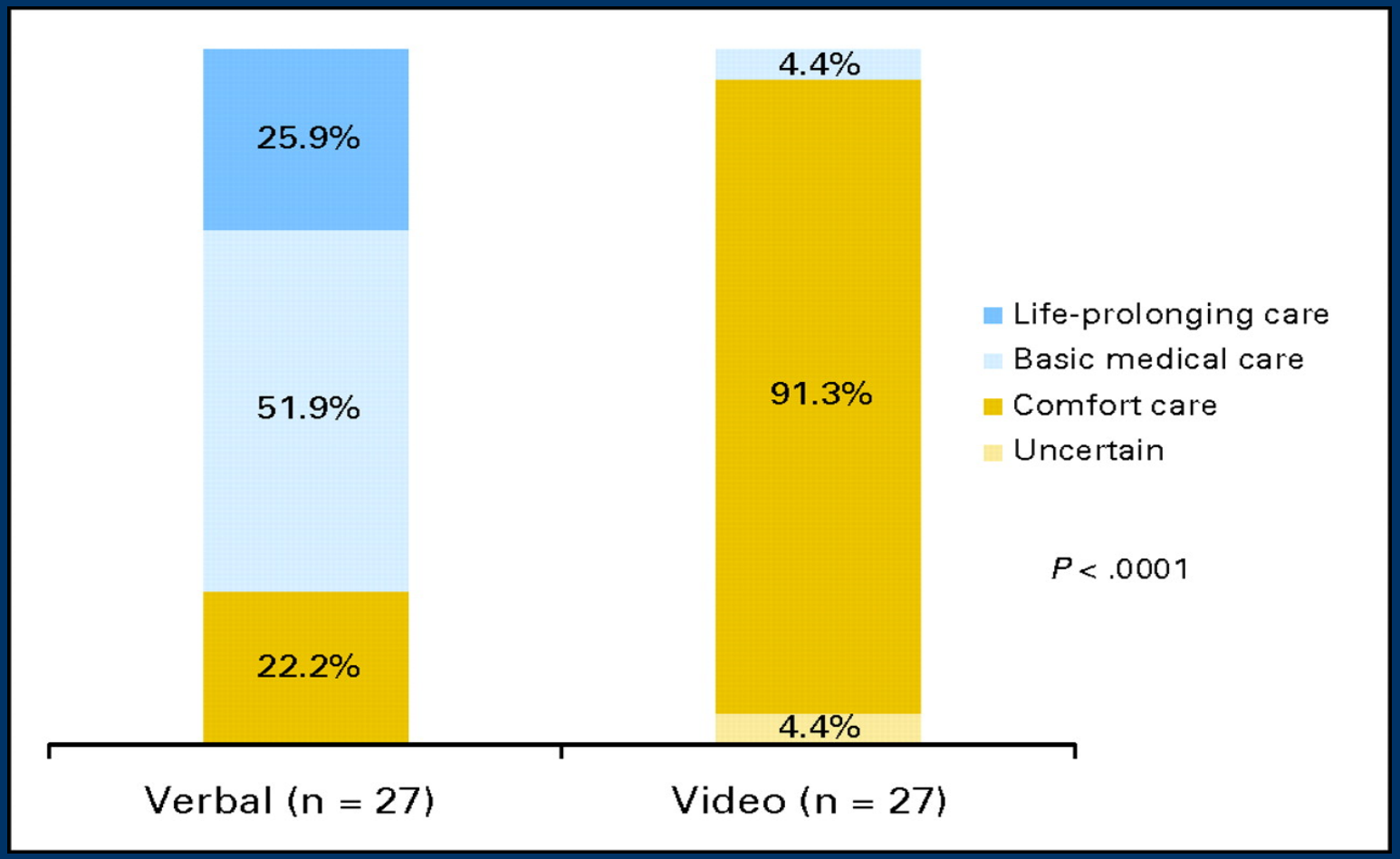
By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)

Summary of Medical Condition	Office Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Effect of a Communication Intervention on Goals-of-care Preferences among Patients with Cancer



-El-Jawahri, A et al. J Clin Oncol. 2010;28:305-10.

-Adapted from Am Soc Clinical Oncology

Discussing Potential Adverse Outcomes before Cardiac Surgery

	ACP Intervention	Control
Knowledge	**8.4**	**7.8**
Congruence	**2.8***	**1.4***
Decisional conflict	**2.0***	**2.3***
Anxiety	**-0.2**	**+1.3**

*p<0.05

-Song MK, et al. A randomized, controlled trial to improve advance care planning among patients undergoing cardiac surgery. Med Care. 2005;43:1049-53.

Respecting Choices

- **Community-wide program in La Crosse, WI**
  - **15% of population had completed an advance directive at baseline**
- **ACP became standard of care across the community**
  - **advance directive educators placed at all health care orgs**
  - **standard policies and practices for documenting, maintaining, and using advance directives**
  - **community-wide education**
- **Two years after program implementation:**
  - **85% of eligible patients had completed an advance directive**
  - **98% of all deaths: treatment matched patient's wishes**

Pilot Advance Care Planning at HCP

Physician	N Patients	AD at baseline, N (%)	AD completed, N (%)
A	**114**	6 (5.3%)	25 (23%)
B	**325**	14 (4.3%)	25 (8%)
C	**150**	13 (8.6%)	10 (7%)
D	**330**	13 (3.9%)	51 (16%)
E	**191**	7 (3.6%)	22 (12%)
F	**312**	11 (3.5)	55 (18%)
Total	**1422**	**64 (4.5%)**	**188 (14%)**

Advance care planning in a SNP

Effect of a nurse care coordinator working with high risk patients

	Advance directive or preferences in medical record
Physician alone	12%
Nurse care coordinator intervention	70%

How do we provide appropriate match of care with prognosis at the end of life?

- **Advance care planning**
  - **Focus on goals of care**
- **Tools to guide end of life care**
- **Symptom management at end of life**
- **Set limits?**

Powerful Motivation to Rescue

- **“Our moral response to the imminence of death demands that we rescue the doomed. We throw a rope to the drowning, rush into burning buildings to snatch the entrapped, dispatch teams to search for the snowbound. This rescue morality spills into medical care where our ropes are artificial hearts…..**
- **Should the Rule of Rescue set a limit to rational calculation of the efficacy of technology?”**

  – **Jonsen A. *Law Med Health Care*. 1986;14:172-4 quoted in the *J Med Ethics*. 2008;34:540-4.**

Patients are "willing to pay" in the setting of rescue

- **Seriously ill patients willing to accept much more burden for a chance at benefit**
  - **Willing to undergo chemotherapy with substantial adverse effects for what chance of cure?**

    1% - metastatic tumor patients

    10% - physicians

    50% - nurses

    50% - general public

  - **Agrawal & Emanuel. *JAMA* 2003; 290:1075-82.**

Cascade of aggressive care in the setting of rescue

Prognosis not discussed / decline not anticipated →

Patient deteriorates / next steps not discussed →

Clinical deterioration merits intensive care →

Organ failure merits more machines →

Ineffective care promotes undignified suffering →

↓ Healthcare morale, ↑Opportunity costs, ↑ Costs

Medical Professionalism in the New Millennium: A Physician Charter

Project of the ABIM Foundation, ACP–ASIM Foundation, and European Federation of Internal Medicine*

- ***Principle of primacy of patient welfare.*** **This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.**

- ***Principle of social justice.*** **The medical profession must promote justice in the health care system, including the fair distribution of health care resources....**

Medical Professionalism in the New Millennium: A Physician Charter

Project of the ABIM Foundation, ACP–ASIM Foundation, and European Federation of Internal Medicine*

- Professional responsibility

Commitment to a just distribution of finite resources. While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals and payers to develop guidelines for cost-effective care……

Medical Professionalism in the New Millennium: A Physician Charter

Project of the ABIM Foundation, ACP–ASIM Foundation, and European Federation of Internal Medicine*

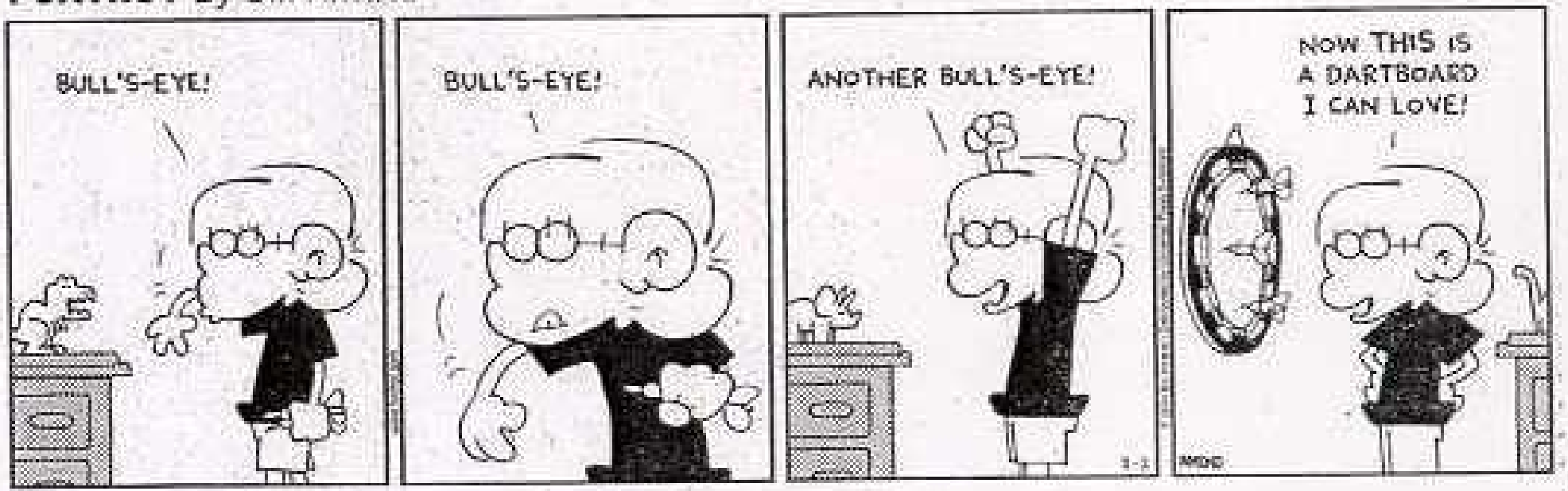
….The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one's patients to avoidable harm and expense, but also diminishes the resources available for others.

Rethinking Case #2: Woman with Dementia and Pneumonia

For the 75 yo woman with advanced dementia and pneumonia who cannot eat or be cared for at home:

- **Consider goals of care - It is OK *not* to place the feeding tube**
- **Permissible to initiate a "trial"**
- **An example of failed advance care planning**
- **Identify deficits to improve care**

FOXTROT By Bill Amend



ARE WE LISTENING?

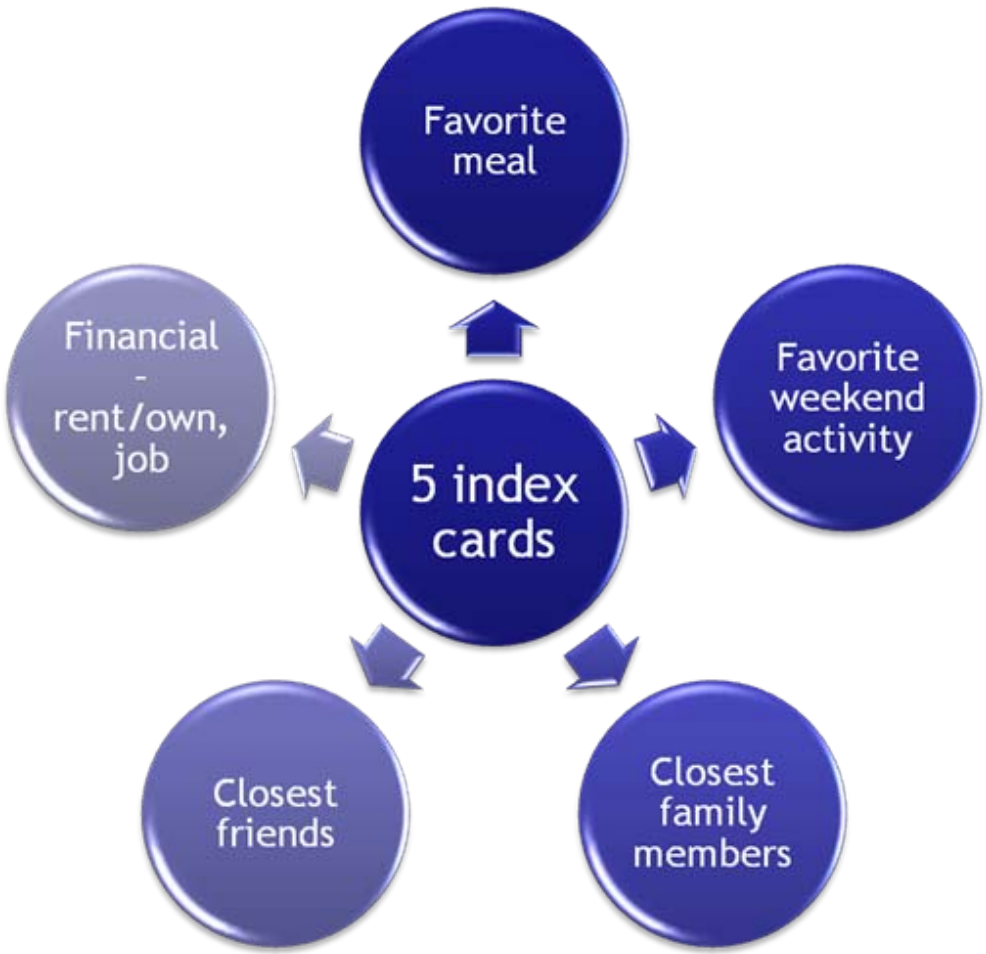
ADDRESSING END OF LIFE PREFERENCES

Susan Stone, MD MPH, Lead Physician
Palliative Care And House Calls

Sayeed Khan, MD, Lead Hospitalist

Karol Attaway, MHA, VP Operations,
HealthCare Partners

Card Game

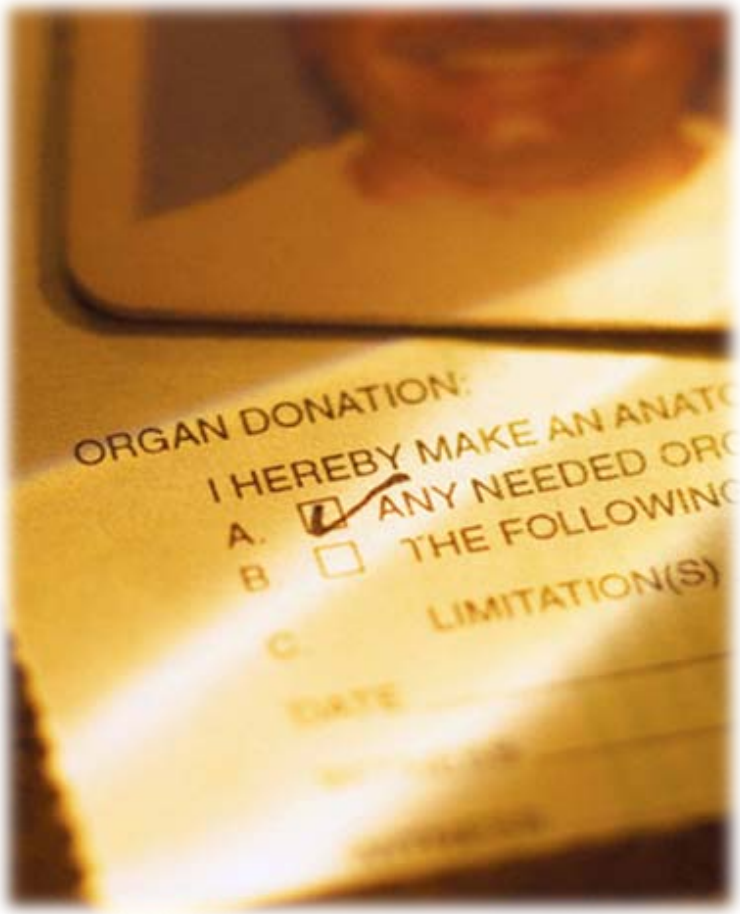

Favorite meal
Financial - rent/own, job
5 index cards
Favorite weekend activity
Closest friends
Closest family members

Every Few Minutes Across The Country….911

- 80 year old male
- History COPD, CHF, DM
- Found by wife slumped over and short of breath
- Just discharged after lengthy hospitalization
- No advance directive

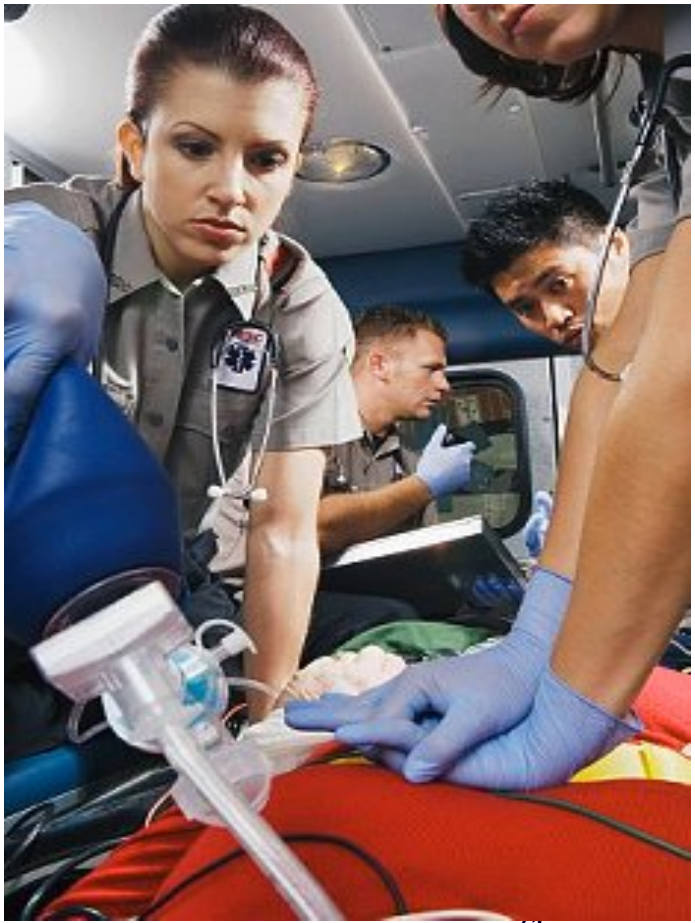
A Heart Too Young To Die?

Do you want us to do everything?



Inaccurate Information About CPR

- General public inflated perception of CPR success
- Acute injury vs. chronic illness.
- This is a time to review/clarify the indications, contraindications, potential outcomes and morbidity of CPR. Start an discussion by asking, "What do you know about CPR?"



Survival after CPR in *(Three Television Series)*

The NEW ENGLAND JOURNAL of MEDICINE

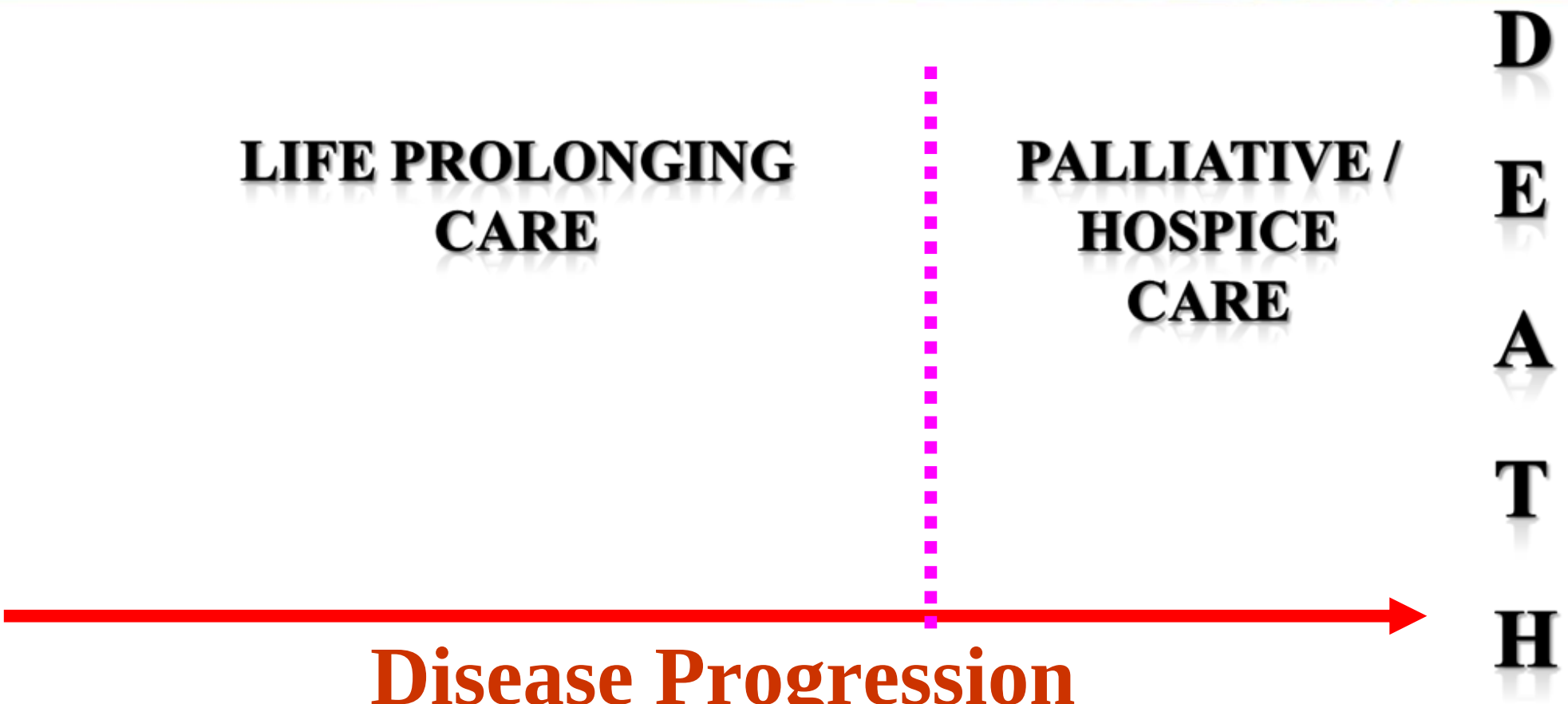
Table 3. Survival after CPR in Three Television Series.

Series	No. of Episodes	No. of Occurrences of CPR	Short-Term Survival after CPR	Survival to Discharge after CPR	Short-Term Survival, Death in Hospital	Short-Term Survival without Follow-up
			number of patients (percent)			
Chicago Hope	22	11	7 (64)	4 (36)	3 (27)	0
ER	25	31	21 (68)	NA*	3 (10)	18 (58)
Rescue 911	50	18	18 (100)	18 (100)	0	0
Total	97	60	46 (77)	22 (37)	6 (10)	18 (30)

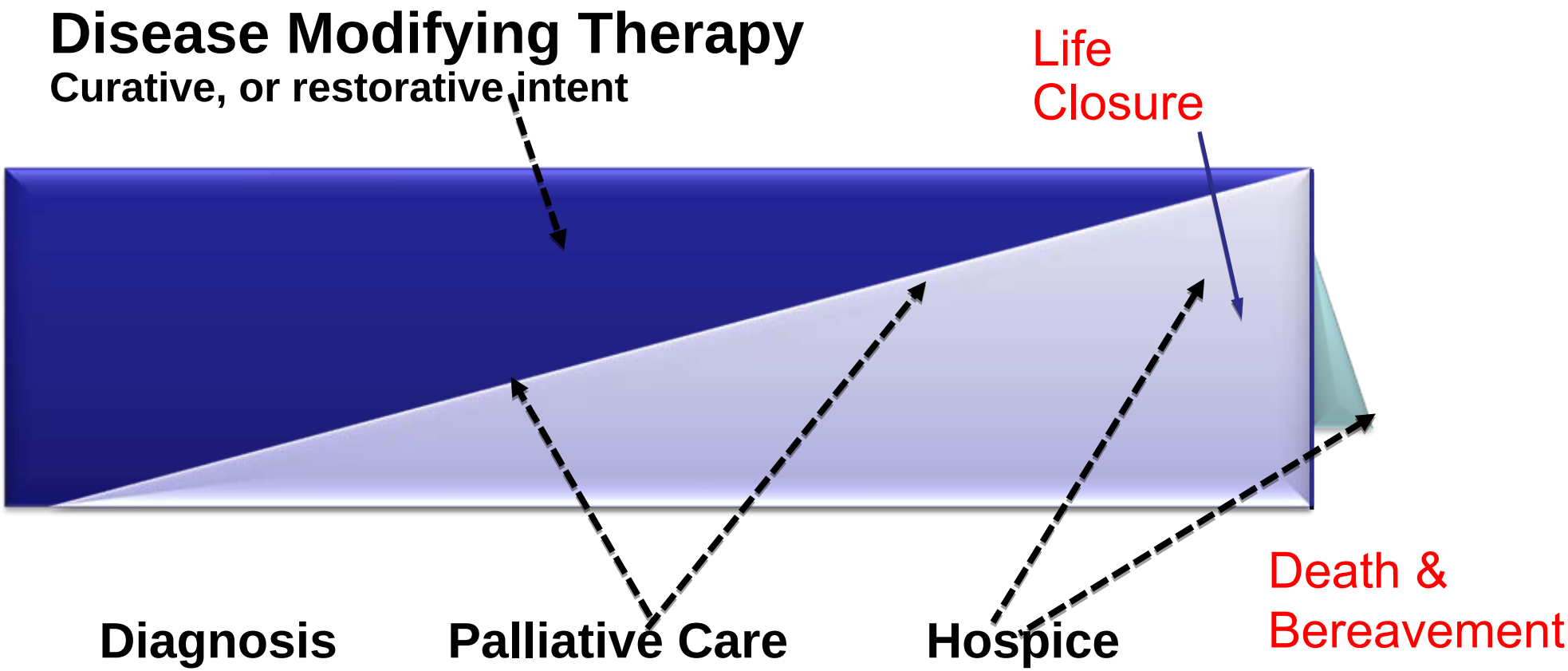
*Not applicable. *ER* deals only with events in the emergency department.

Diem SJ. Lantos JD. Tulsky JA. Cardiopulmonary resuscitation on television. Miracles and misinformation. New England Journal of Medicine.1996;334(24):1578-82.

The Cure - Care Model: The Old System



A New Vision of Palliative Care



NHWG; Adapted from work of the Canadian Palliative Care Association & Frank Ferris, MD

CHCF Survey of Californians 2011

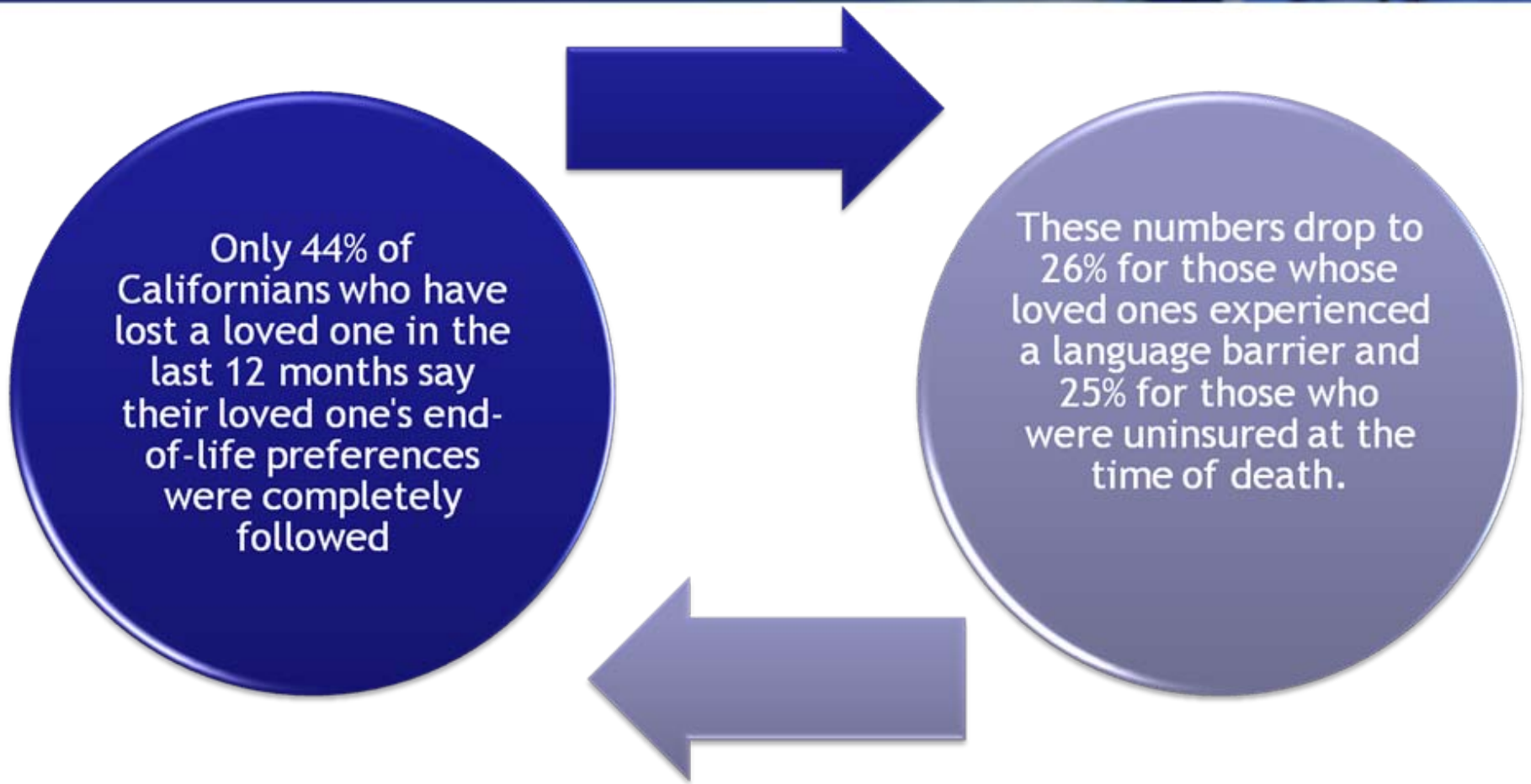
California Healthcare Foundation (www.chcf.org)

What is Important?

Most important factors at the end of their life

- Making sure family is not burdened financially by the costs of care (67%) "extremely important".
- Being comfortable and without pain (66%)

Wishes Followed?



Discussing Wishes

- Play video

Advance Directive

- More detail about an individual wishes and preferences for treatment.
- Most common mechanism for designating a surrogate decision maker
- POLST does not provide for the designation of a surrogate decision maker.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2009)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A — Cardiopulmonary Resuscitation (CPR): *Person has no pulse and is not breathing.*

Check One

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)
(Section B: Full Treatment required)

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B — Medical Interventions: *Person has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Do Not Transfer to hospital for medical interventions. Transfer*** if comfort needs cannot be met in current location.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C — Artificially Administered Nutrition: *Offer food by mouth if feasible and desired.*

Check One

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D — Signatures and Summary of Medical Condition:

Discussed with:

☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other:

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Decisionmaker, Parent of Minor or Conservator

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)

Summary of Medical Condition	Office Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

MGO-CLIN-040 (9/09)

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle)	Date of Birth	Gender: M F
Patient Address		

Contact Information

Health Care Decisionmaker	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professional

Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date this line.
- A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.

For more information or a copy of the form, visit **www.capolst.org**.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

POLST

POLST does not replace an Advance Health Care Directive (AD).

AD can provide a significant amount of more detail about an individual wishes and preferences for treatment. In addition, the AD is the most common mechanism for designating a surrogate decision maker for the patient.

Palliative Care Reduces Costs

Cost and ICU Outcomes Associated with Hospital Palliative Care Consultation

	Live Discharges			Hospital Deaths		
Costs	Usual Care	Palliative Care	Δ	Usual Care	Palliative Care	Δ
Per Day	$867	$684	$183*	$1,515	$1,069	$446*
Per Admission	$11,498	$9,992	$1,506*	$23,521	$16,831	$6,690*
Laboratory	$1,160	$833	$327*	$2,805	$1,772	$1,033*
ICU	$6,974	$1,726	$5,248*	$15,531	$7,755	$7,776***
Pharmacy	$2,223	$2,037	$186	$6,063	$3,622	$2,441**
Imaging	$851	$1,060	-$208***	$1,656	$1,475	$181
Died in ICU	X	X	X	18%	4%	14%*

*p<.001
**p<.01
***p<.05

Morrison, RS et al. J Amer Geriatr Soc 2007;55:S7

Am I Doing the Right Thing?

Focus groups: 14 physicians, 6 nurses, 2 social workers and 4 technicians

Six themes:

- Palliative care equals end of life
- Disagreed about feasibility of use in ED
- Family panics and brings in palliative care patient
- Poor communication between ED and outpatient provider re:goals** (POLST)
- Conflict around withholding life prolonging treatment
- Inadequate training in pain mgt

Obstacles

Attitudinal

- Palliative care not focus of ED providers
- Emotionally challenging
- Not being able to act is frustrating

Structural

- Environment not appropriate
- ED providers don't know the patients
- These patients are lower priority

Can Lead A Horse To Water….

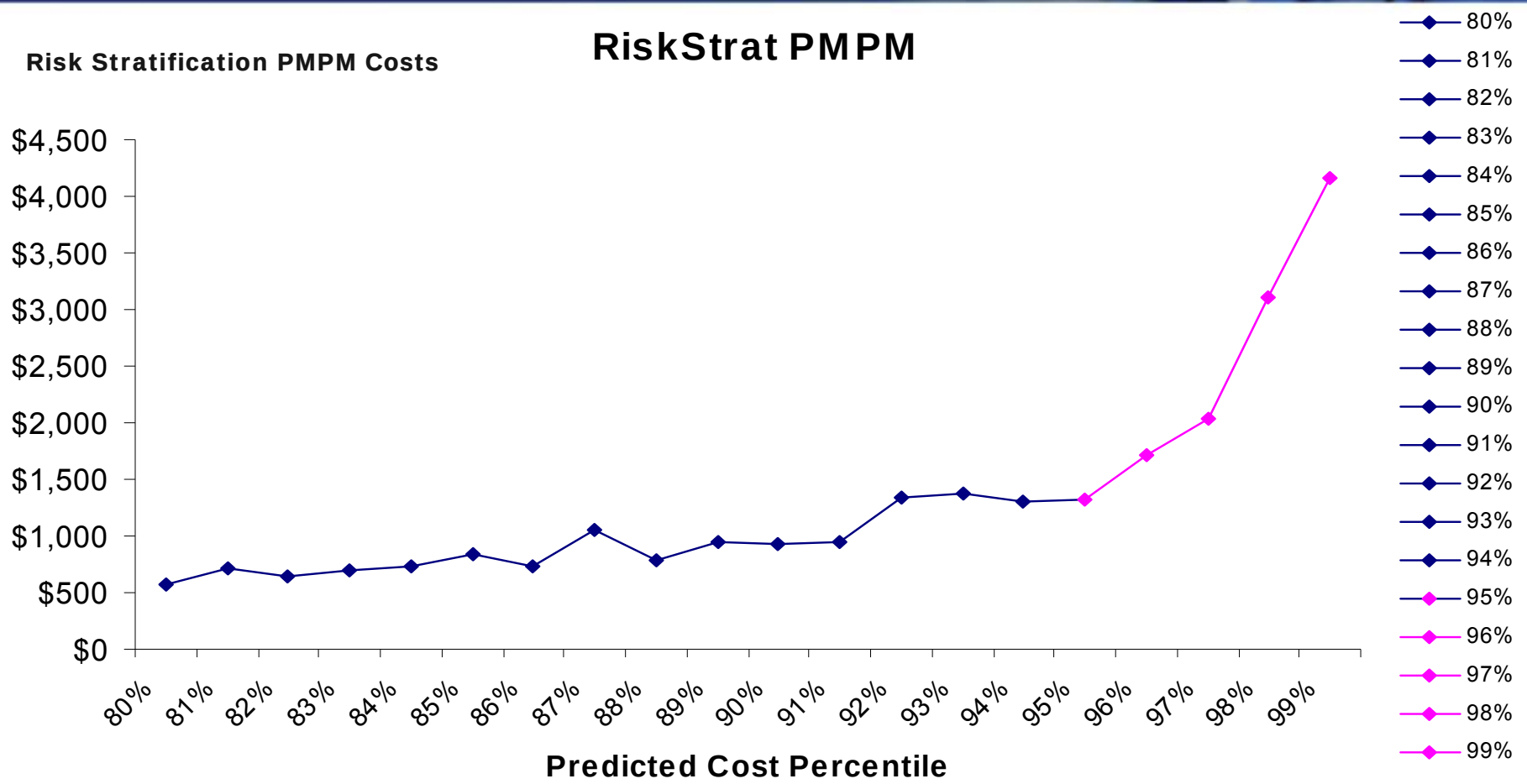
FIVE WISHES

- HAVE CROWD FILL OUT

The hospital bedside is not the ideal location to have the initial end of life discussions

"No one has ever told me this before"

Target Patient Population



HCP Clinical Integration for Chronically Frail Complicated Patients

Hospice/Palliative Care

Home Care Management

Provides in-home medical care management by specialized physicians, nurse care managers and social workers for chronically frail seniors that have physical, mental, social and financial limitations. Chronically disabled patients receive specialized integrated home care programs

High Risk Clinics and Care Management

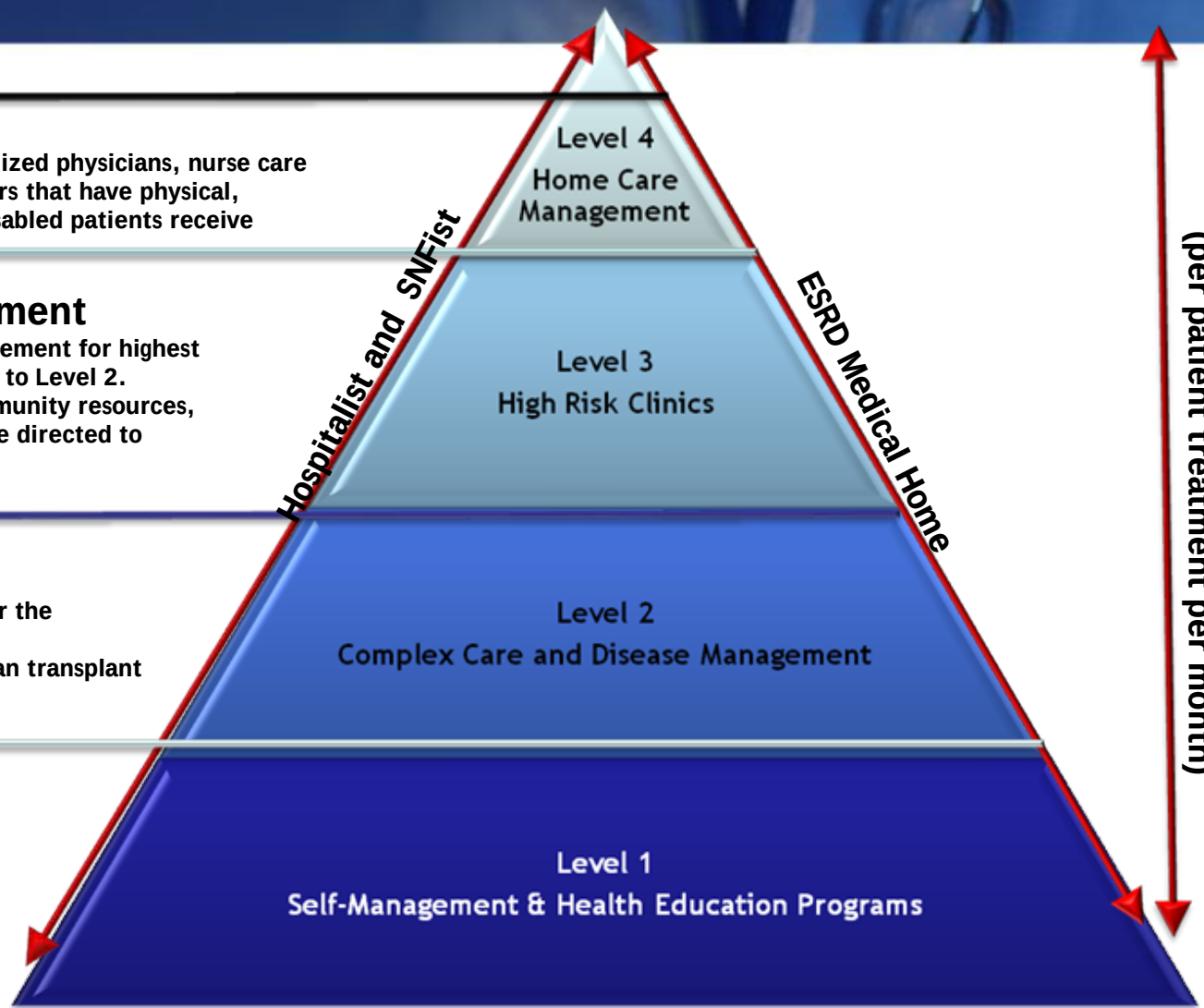
Provides one-on-one physician /nurse, and case management for highest risk population. As risk is reduced, patient transferred to Level 2. Physicians and care managers are integrated into community resources, physician offices, or clinics. Chronically mentally ill are directed to specialized medical clinics

Complex Care and Disease Management

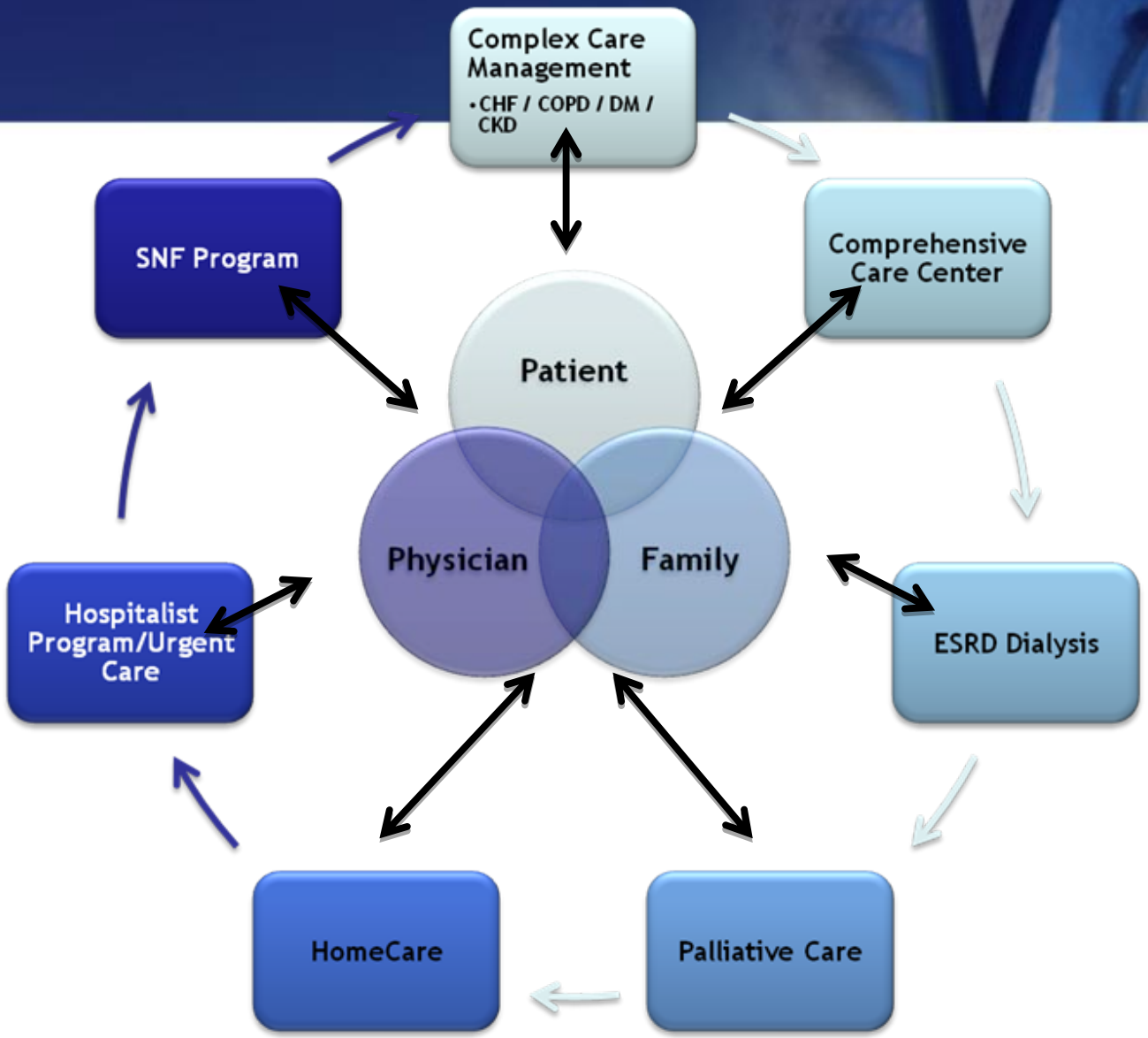
Provides long-term whole person care enhancement for the population using a multidisciplinary team approach. Diabetes, COPD, CHF, CKD, Depression, Dementia, Organ transplant and Cancer.

Self Management, PCP

Provides self-management for people with chronic disease and prevention services.



Care Model


Complex Care Management
• CHF / COPD / DM / CKD
Comprehensive Care Center
ESRD Dialysis
Palliative Care
HomeCare
Hospitalist Program/Urgent Care
SNF Program
Patient
Physician
Family

Medical Risk Management Overview

HCP Manages Costs Utilizing Integrated and Data Drive Management Tools:

- Comprehensive data analysis focuses on high impact clinical interventions
  - Homecare Programs
  - Dialysis Medical Home
  - Comprehensive Care Clinics
  - Palliative Care and Hospice Programs
  - Hospitalists/ SNFist
  - 24/7 Nurse Access Phone Lines

Clinical Quality

We focus on:

Coordinated hospital care

Care coordinated by a PCP

Special programs for chronically ill and frail patients

Preventive care and health education

Disease management

High Risk Programs

Take a "modifiable" cohort of patients based on some criteria (total cost, potential or actual high utilization) and apply them to systems, processes, and specialized teams to improve outcomes.

- Hospitalist Programs
- SNF Programs
- Home Care
- High Risk Clinics
- ESRD - HD Program
- Disease Management (CHF, COPD, DM, CAD, etc.)

HCP Hospital Strategy

HCP does not own Hospitals

HCP -long term Hospital Partnerships > 10 years

Innovative Hospital Contracting Strategy including Cost Plus model where share savings with hospital partners for increased efficiency

Hospital TCU's with Cost Plus Reimbursement

Hospital Partnerships include Hospital Efficiency and through-put benefiting Hospital Medicare FFS DRG management

Hospitalist strategy with hospitals for non-HCP patients benefiting the Hospitals and Community Physicians

Components Leading to a Successful Hospitalist Program

- Improve hospital through-put
- Improve ER core measures - MI, Community Acquired Pneumonia, etc.
- Improve Medi-care DRG 30 day readmission rate
- Decrease unnecessary admissions (proven program results with indigent and Medi-Cal patients)
- Partner with community medical groups

High Risk - Comprehensive Care Center

The Comprehensive Care Centers and HomeCare provide:

- Medications management
- Advance care planning
- Disease education
- Access to additional community resources
- 24-hour on-call access to a high risk program provider.

The CCCs and HomeCare

- Facilitate continuity of care
- Coordination of treatment plans across multiple providers.

The teams document in TouchWorks to facilitate care coordination and keep the patient's PCP abreast of the patient's care plan.

HomeCare Services- Example of the Homebound Frail Senior

Patients Will Benefit

- House Calls
- 24-Hour Contact with HomeCare Team
- Care Planning
- Medication Monitoring
- Coordination of Care
- Communication and Education
- Access to Community Resources
- Caregiver support, education and coordination

HCP Outcomes and Benefits

- Reduction in Hospital Admits and Days
- Reduction in ER Utilization
- Reduction in Deaths in Hospital and ICU
- Improved Advanced Care Planning and Documentation
- Improved Patient Satisfaction and Quality of Life
- Improved Treatment Adherence

High Risk Programs
Home Care

Home Care Program

- Top 2-3% most at-risk patients
- Comprehensive assessment:
  - Living conditions
  - Social and financial needs
  - Medication regimen
  - Medical and behavioral health
- Advanced Care Planning
- Palliative care

	APT	DPT	ER/1000	UC/1000
Pre-Program	1361	5615	935	537
In-Program	995	3956	794	386

2,780 Distinct Patients: 21,247 member months

High Risk Program Outcomes

High Risk Programs have shown a decrease in hospital days and ER utilization

- Example: Comprehensive Care Center Outcomes
  - 25% decrease in Days per Thousand
  - 26% decrease in Admits per Thousand
  - 27% decrease in ER visits

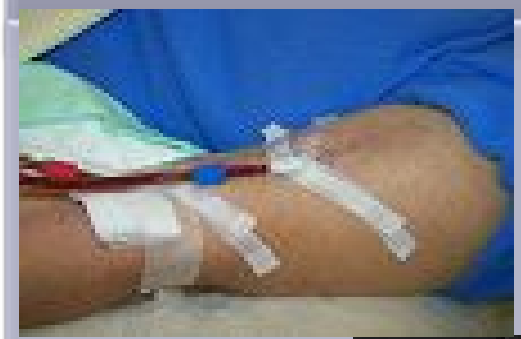
End Stage Renal Disease (ESRD)

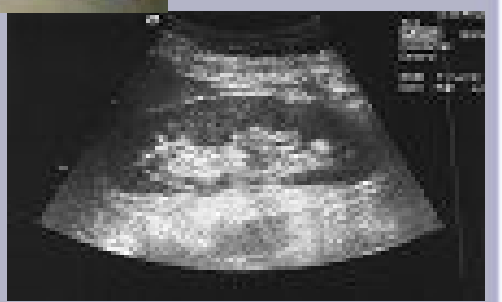
End Stage Renal Disease (ESRD)

The goal of the ESRD program, whose target group is pre-dialysis and dialysis patients, is to improve the quality of care of these patients and decrease the unnecessary utilization of institutionalized care. The program's primary objectives are to:

- Decrease avoidable admissions and Acute/ER utilization
- Reduce emergency vascular interventions
- Increase treatment adherence (renal and other co-morbid diseases) and promote self management
- Improve primary care provided to dialysis patients
- Establish Early Access Placement
- Prepare for scheduled transition to dialysis
- Prepare every patient and caregiver emotionally and physically prior to the need to start dialysis.

Similar to aforementioned high risk programs, the ESRD program is comprised of a multidisciplinary team, including an HCP Nephrologist, Nurse Practitioner, Social Worker and Care Manager. This team does intense patient monitoring and early intervention on patients in trouble, and following admissions.





ESRD PROGRAM

291 Patients enrolled

Year 1:

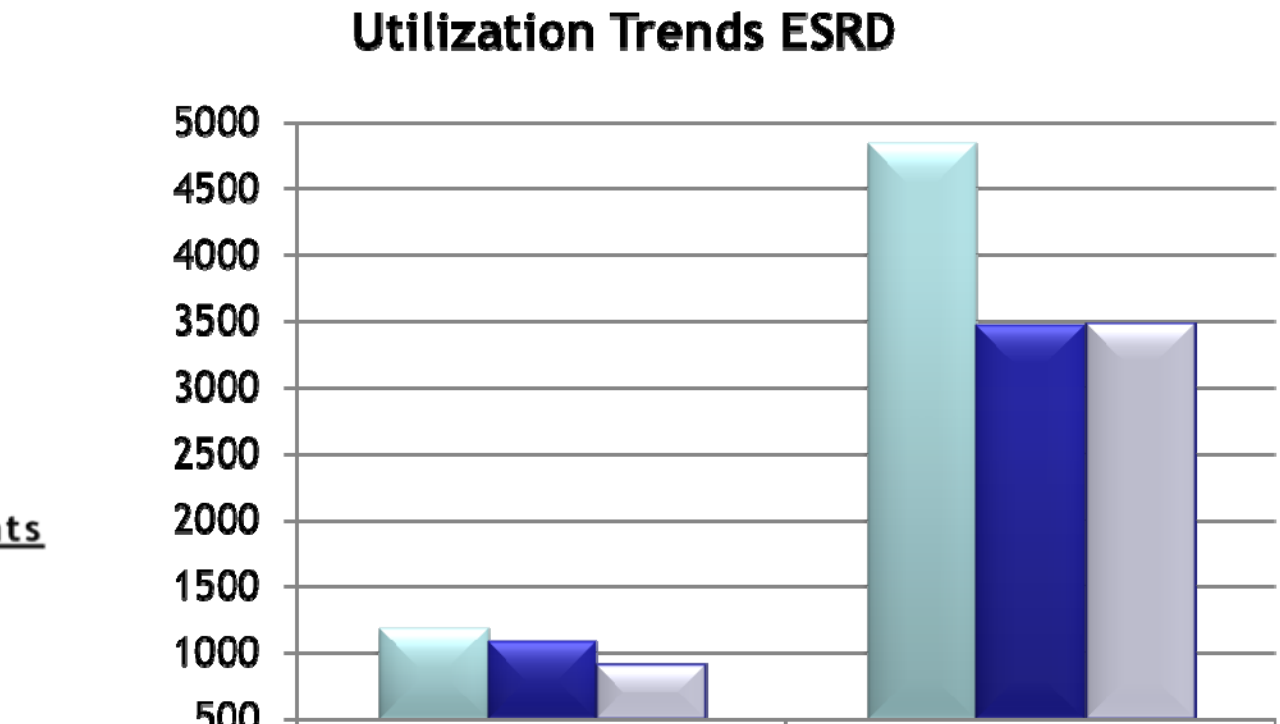
- 9% decline APT
- 28% decline DPT

Year 2

- 15% decline APT
- DPT equal to Yr 1

Best Performing (R2) Unit 96 patients

- 20% decline APT
- 34% decline DPT



	APT	DPT
Pre-program	1185	4843
Year 1	1079	3469
Year 2	913	3474

Nurse Practitioner's Role

The role of the program's Nurse Practitioner is to:

Well patient care, including P4P measures and active treatment to prevent decomposition of heart failure and associated co-morbidities, is also part of the NP's role.

monitor patients outside of dialysis centers and coordinating with the Nephrologist, PCP and other specialists.

work in collaboration with community nephrologists to formulate treatment plans.

follows pre-dialysis patients' GFR to identify appropriate time to start dialysis.

monitors patients and manages patient care within HCP contracted dialysis centers,

The Social Worker's Role

The Social Worker

- assesses the patient's home and caretaker environment, and addresses other psychosocial issues.

The Care Manager's Role

is responsible for regularly checking up on the patient to ensure stabilization of patient between visits and to coordinate the care pre and post dialysis.

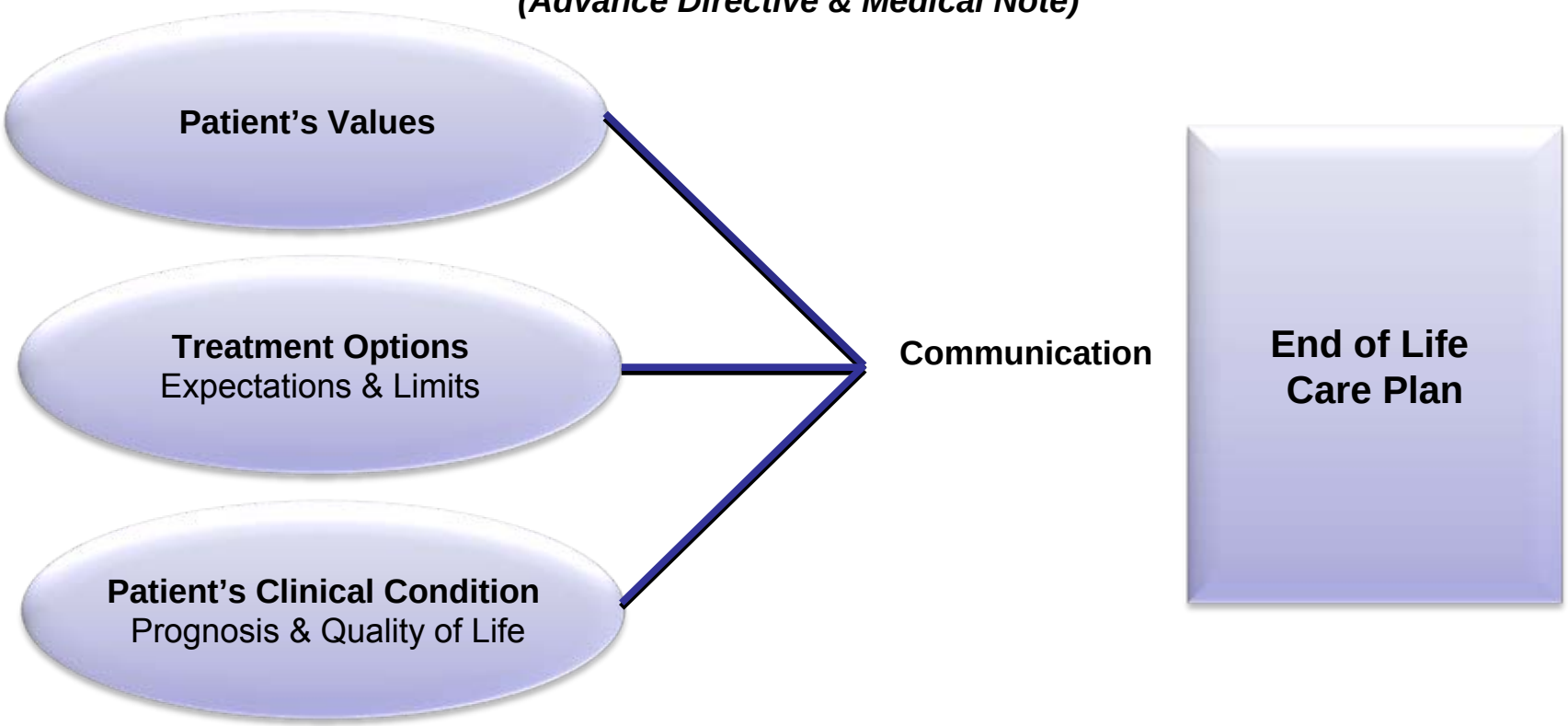
HCC step up

	Year Prior	Program Year 1	Year 2
CCC	2.74	3.54	3.32
HomeCare	2.9	3.91	3.56
ESRD	3.54	4.75	4.7

Projected 2011:Seniors Member Mo: 4900 HC, 10000 CCC
HCC Revenue increase – $3.9M HC, $6.4M CCC

Advanced Care Planning and Palliative Care

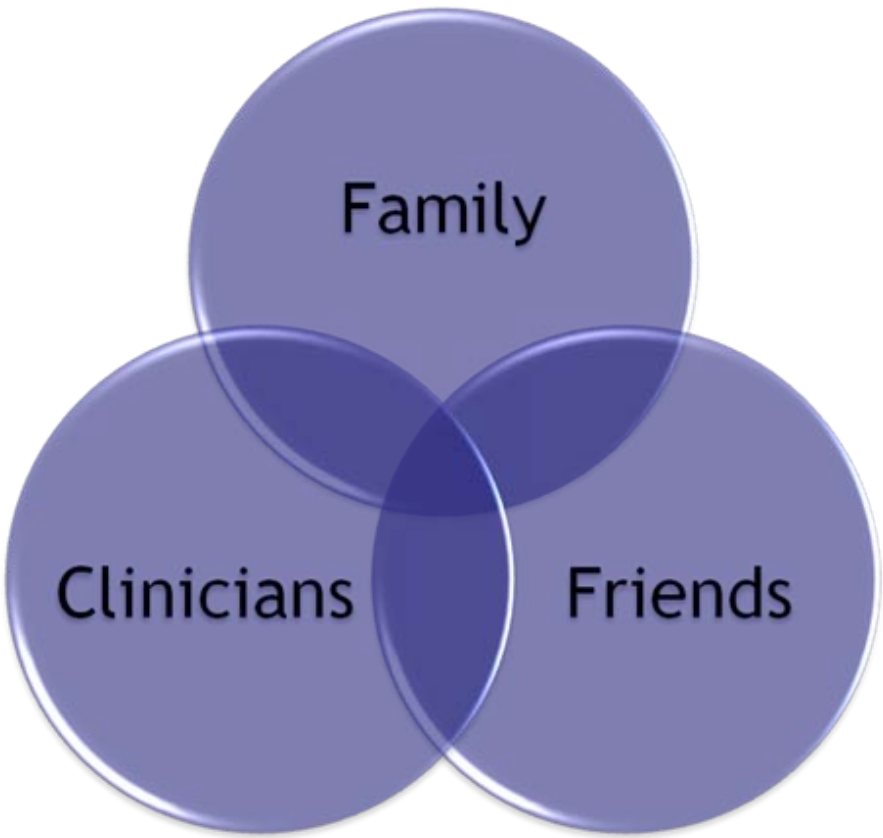
Improve Competency in End of Life Management
Focus on Goals of Care, Quality, & Dignity
Complete an Advance Care Plan
(Advance Directive & Medical Note)



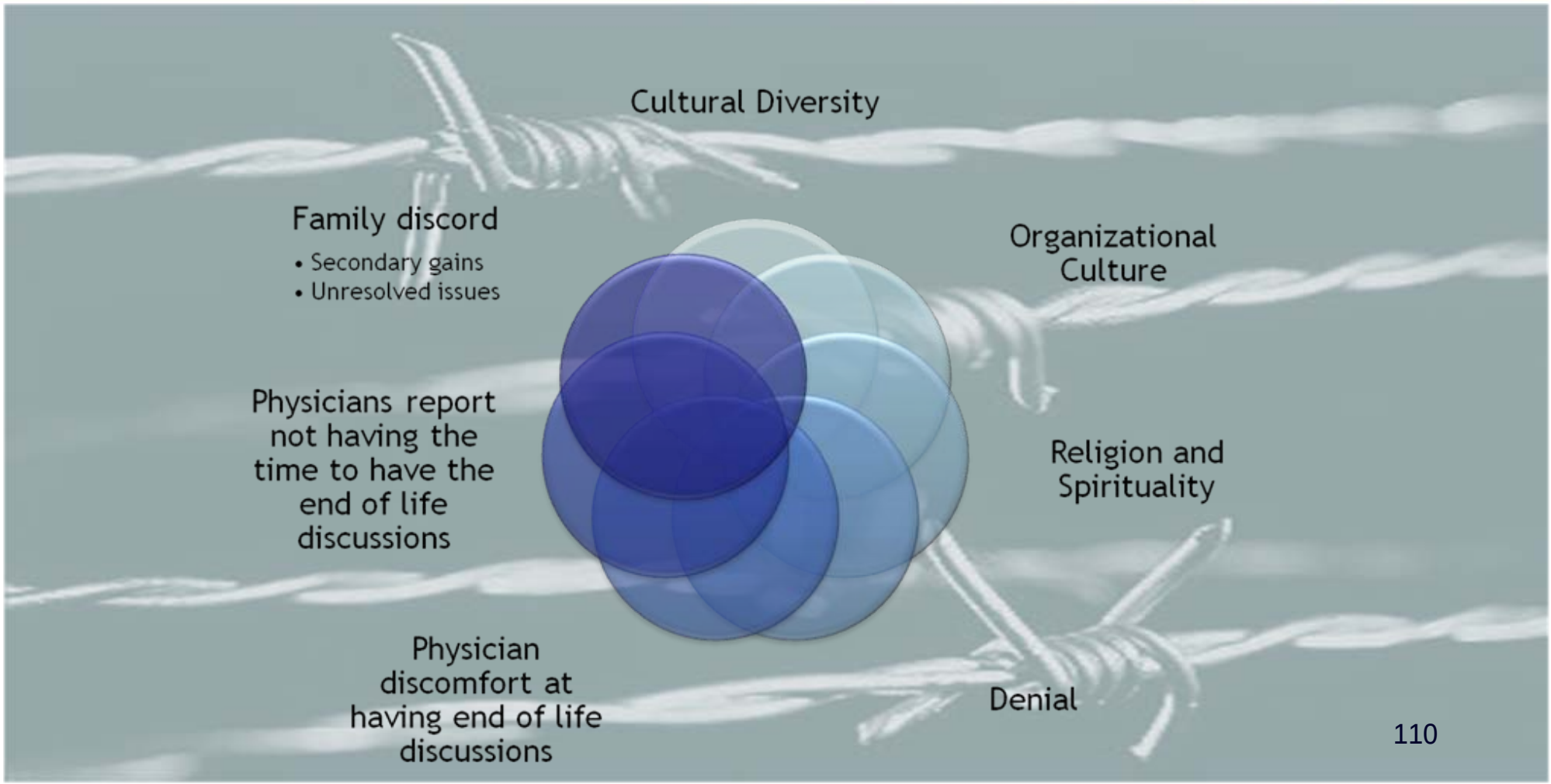
How Do We Become Better Listeners?

How can we make it easier for our patients to talk about end of life preferences?

How Do We Become Better Listeners?



Barriers


Cultural Diversity
Family discord
• Secondary gains
• Unresolved issues
Organizational Culture
Physicians report not having the time to have the end of life discussions
Religion and Spirituality
Physician discomfort at having end of life discussions
Denial

How Do We Start To Listen?

Must be part of the organizational strategy with sufficient resources allocated

How Do We Start To Listen?

Understand the implications of Cultural Preferences

Religion, religiosity and spirituality often associated with personal racial/ethnic affiliation, has been shown to be associated with measures that prolong life, reluctance to withdraw life support. (Boussarsar, M, Bouchoucha, S.; 2006)

How Do We Start To Listen?

Early identification

Create coordinated glide path

- High Risk Programs
- Risk Stratification – electronic medical records
- Development of diagnosis based automatic referral triggers for Palliative Care consultations
- Intensive outreach efforts to identify patients

How Do We Start To Listen?

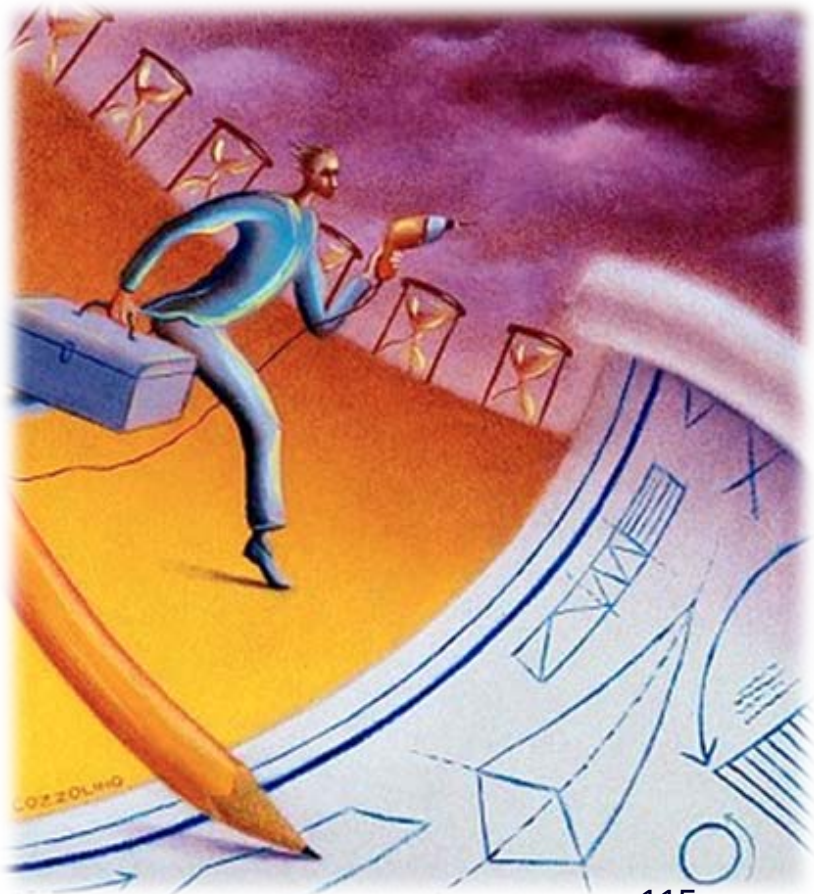
Honest informed choices

Patient Entitlement vs. Reality

- Courageous clinicians

Tools

- RAF Scores
- High Risk Programs
- Vulnerable Elder Screening -VES 13
- Question piloted at the Veteran's Hospitals
- 'Would you be surprised if this patient dies within the next year?'
- Advanced directive initiative for all patients



Tools

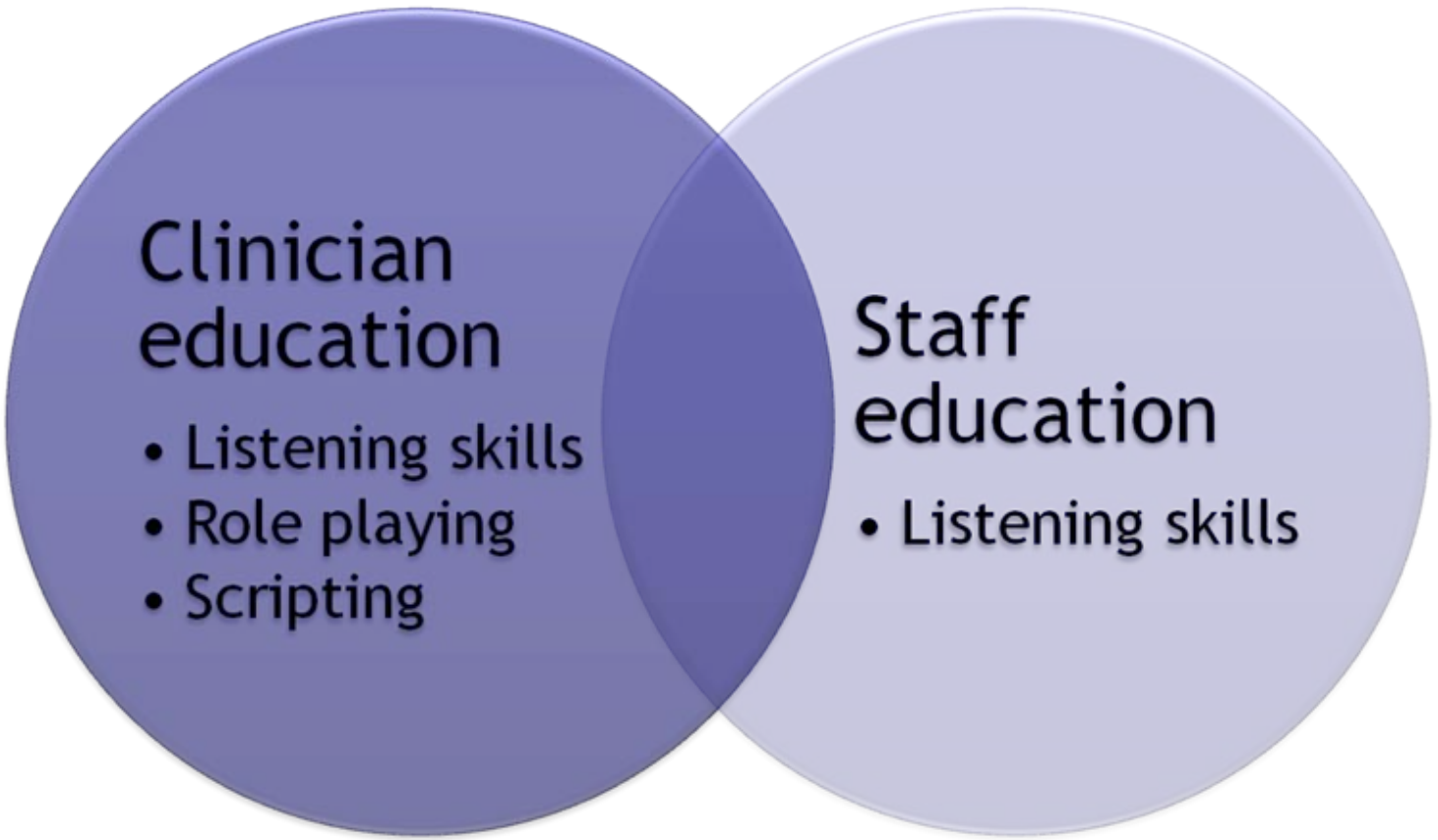
IPA Contract includes compensation for discussion and submission of the signed advanced directive.

It Is **NOT** All About The Doctor!

Team Approach

Ideas On How We Can Tackle This Disconnect

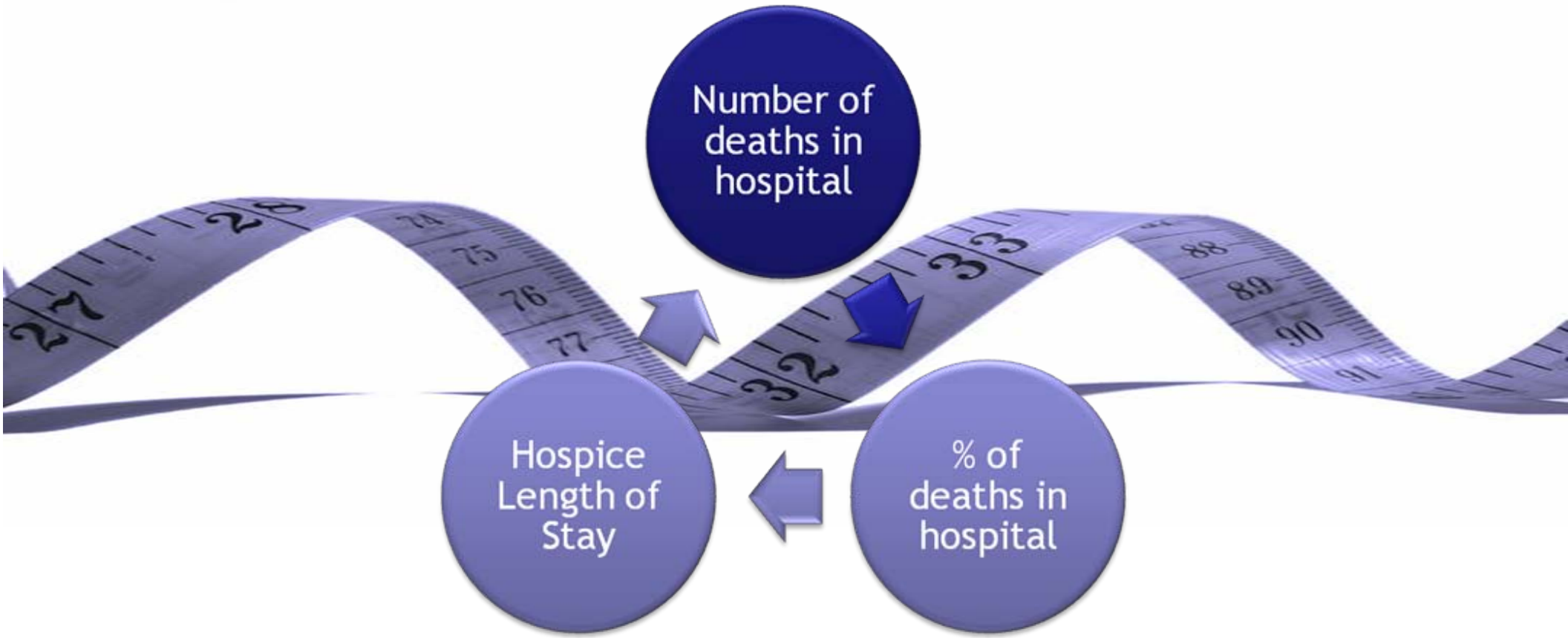
- Breakfasts
- Staff being asked to become notary's
- Promoteras
- Social Worker, Medical Assistants, Patient Liaisons
- Tools
- Wall Art


Clinician education
• Listening skills
• Role playing
• Scripting
Staff education
• Listening skills

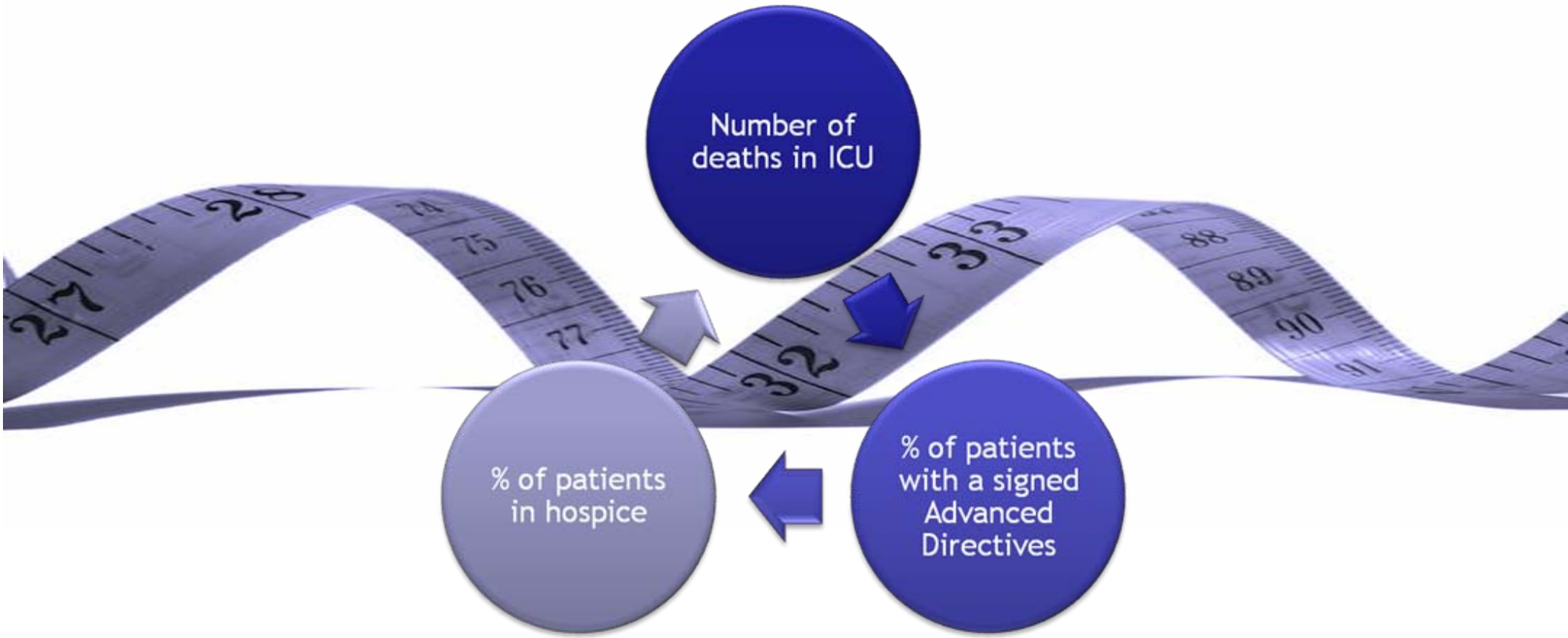
P4P Incentives Work!

P4P programs linking financial payments with achievement of high quality care being utilized to improve outcomes and encourage appropriate utilization

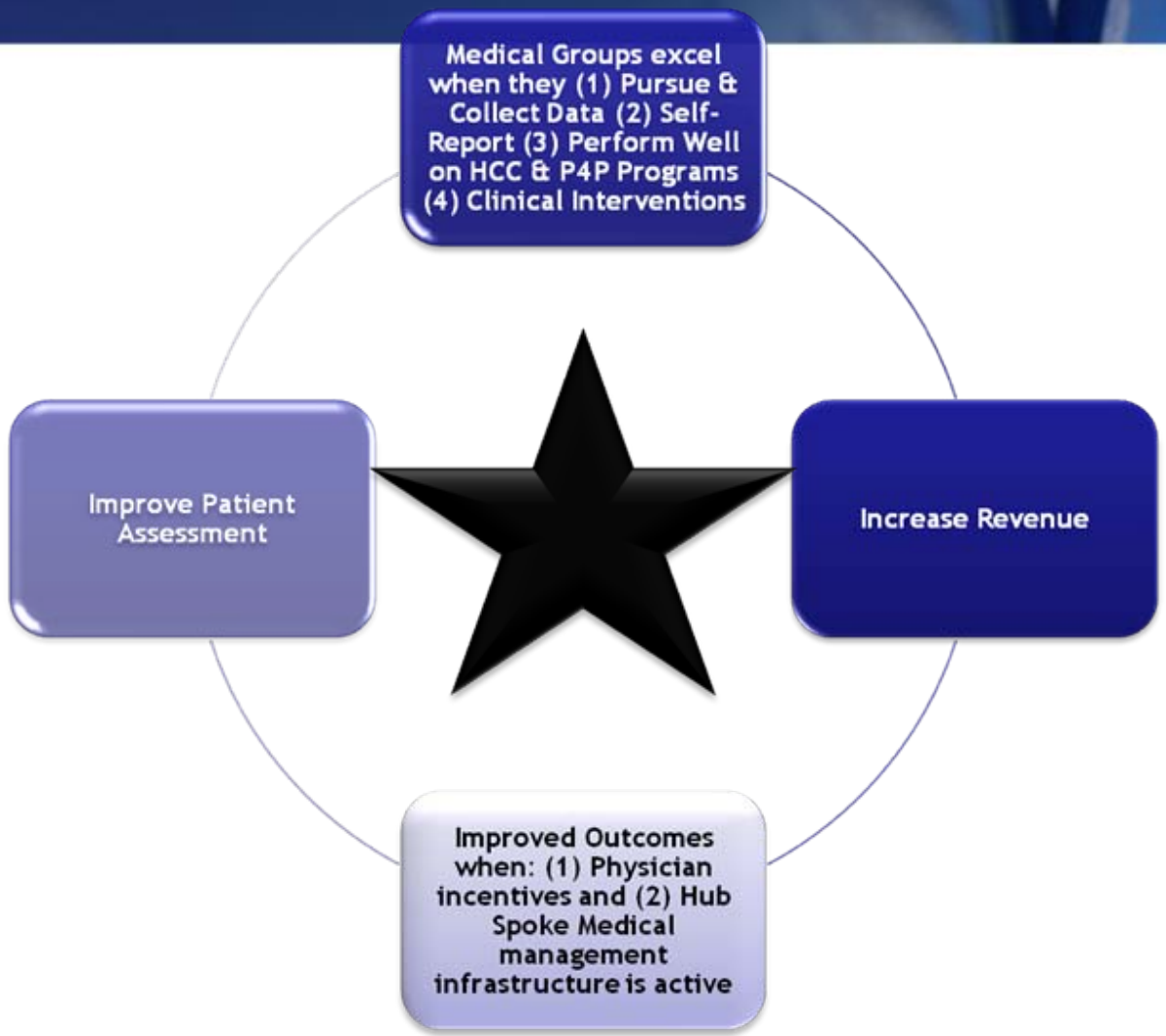
Current Measures



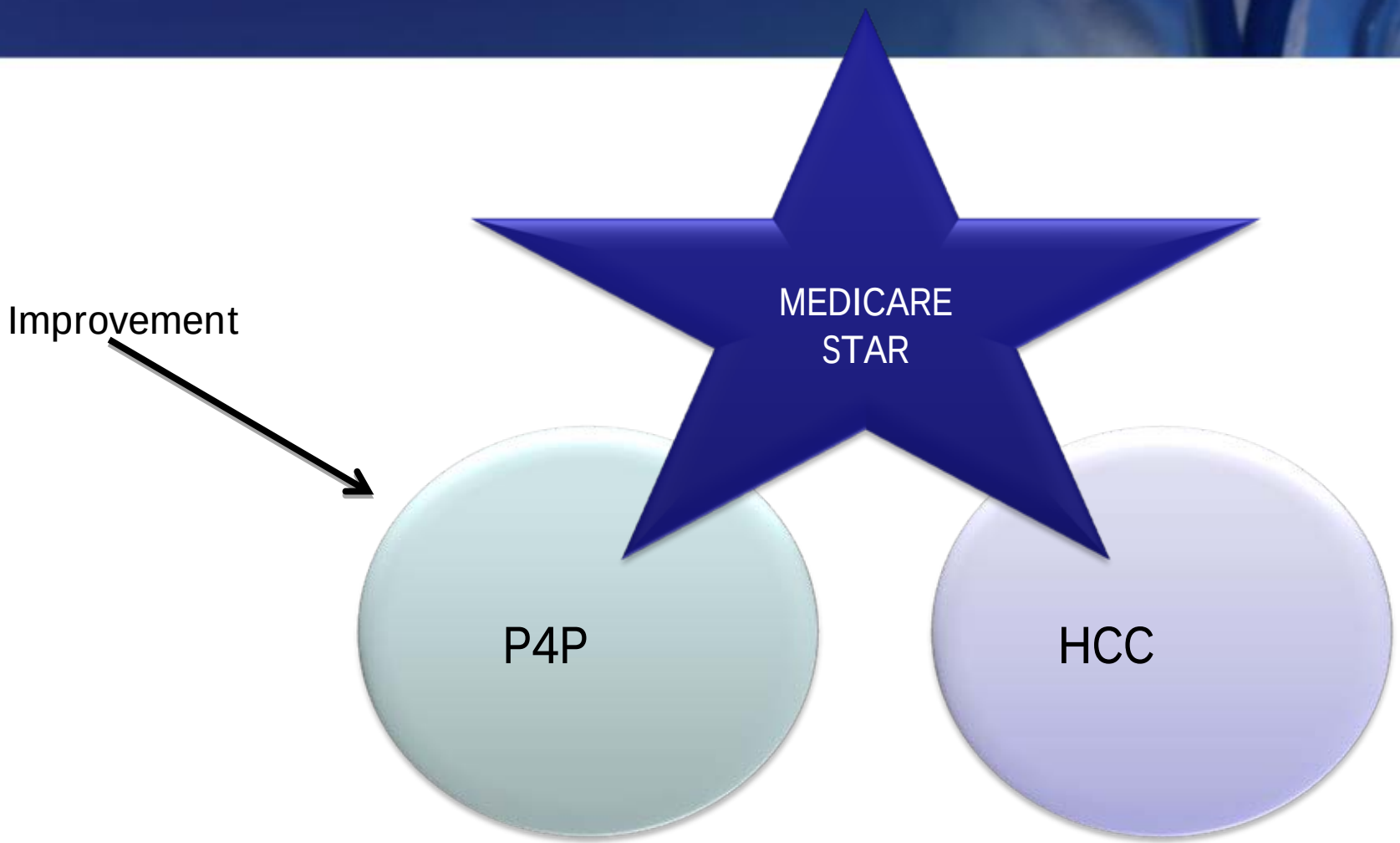
Recommended Measures



Medicare Star P4P



P4P + HCC + Medicare Star



Why Did This Work?

For referring clinicians improved care for patient and potentially decreased workload for clinicians thought to be prime factors.

SHARP HospiceCare
Transitions Program

Managing Chronic Care Better

Jerry Penso, MD, MBA

Medical Director, Continuum of Care

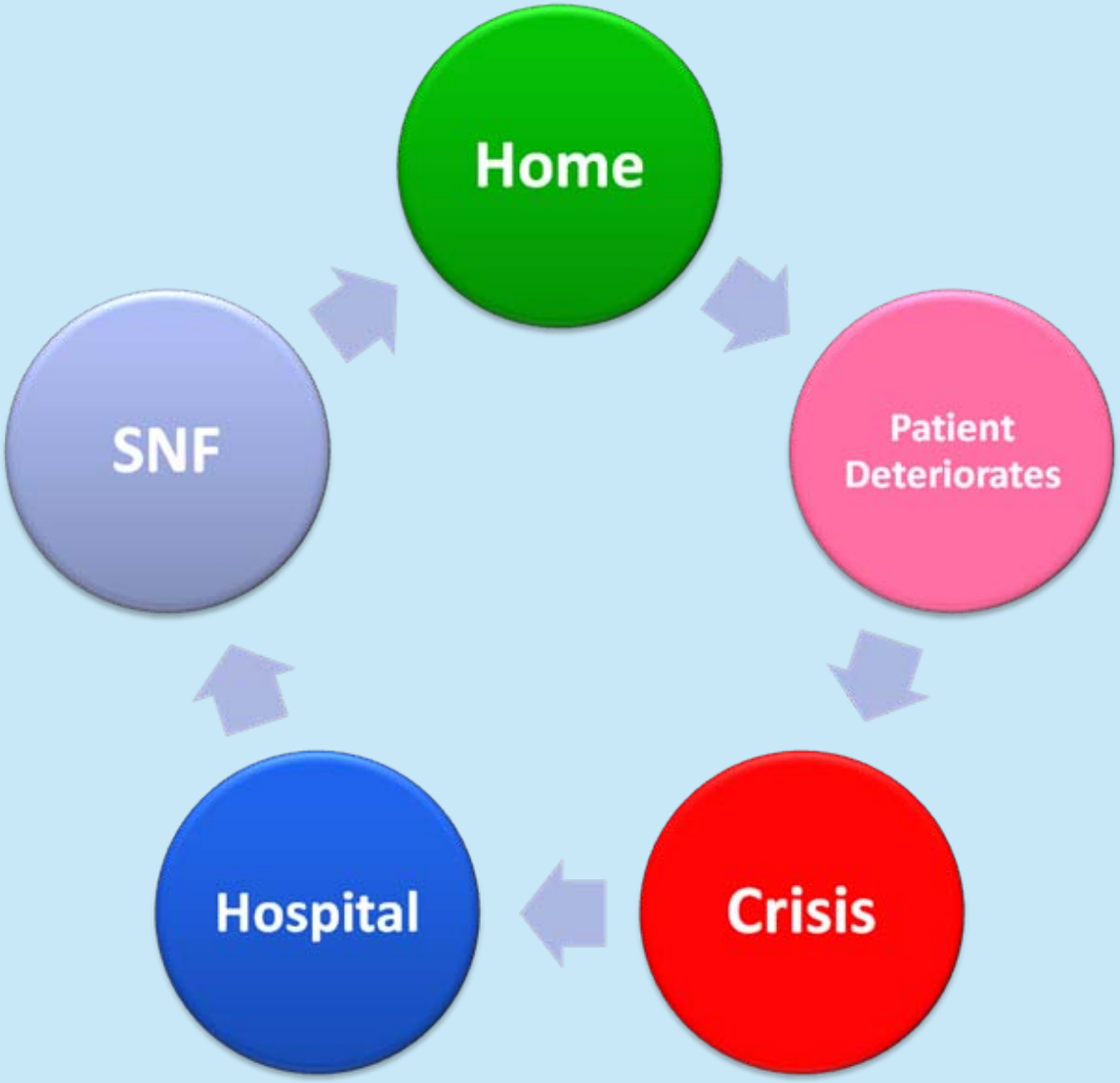
Sharp Rees-Stealy Medical Group

SHARP Hospice Care

Malcolm Baldrige National Quality Award 2007 Award Recipient Sharp HealthCare

SHARP Hospice Care

Traditional Reactive Model



Problems with Traditional Reactive Model

- Poor quality of life
- Low patient satisfaction
- Low family satisfaction
- Worse outcomes

SHARP Hospice Care

Mean Survival increased by **29 days** for patients who chose hospice over non-hospice care

CHF	+ 81 days
Lung Cancer	+ 39 days
Pancreatic Cancer	+ 21 days
Colon Cancer	+ 33 days
Breast Cancer	+ 12 days
Prostate Cancer	+ 4 days

Steven Connor PhD, et al, *Journal of Pain and Symptom Management,* March 2007, Vol (3) pp 238-246

SHARP Hospice Care

"Cure" Mentality

Percent of patients with incurable terminal disease who believed they could have been cured

Unresectionable non-small-cell lung cancer	54%
AIDS	32%
CHF	22%
ALS	16%
COPD	12%

Daniel P Sulamsy, OFM, MD, PhD, et al, *The Accuracy of Substituted Judgment in Patients with Terminal Diagnoses,* April 1998, Annals of Internal Medicine, Vol 128(8), PP 621-29

SHARP Hospice Care

"The continued application of traditional treatment strategies which are valuable to the patient at an earlier time in their health experience has the opposite effect on patients at end of life resulting in inferior outcomes."

Daniel Hoefer, MD
Associate Medical Director
Sharp HospiceCare

Sharp HealthCare

Founded 1955

7 Hospitals

2 Skilled Nursing Homes

1 Home Health

2 Hospice

3 Charitable Foundations

1 Medical Group – Sharp Rees-Stealy

1 IPA – Sharp Community Medical Group

Sharp Rees-Stealy Medical Group

Affiliated with Sharp in 1985

Staff Model
215,000 patients
400 Physicians
27 Specialties
21 sites

Sharp Community Medical Group

Formed 1989

IPA Model

140,000 patients

200 Primary Care Physicians

700 Specialist Physicians

The Vision
Transforming the Model

Transitions is a home-based program designed to provide expert consultative palliative care to patients with advanced chronic illness.

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Transitions Program Goals

- Educate patient/family
- Use professional prognostic skills to prepare the patient and family (the “when” not the “if”)
- Enhance coordination of care
- Facilitate development of a long term care plan that aligns with patient goals of care
- Improve the end-of-life care

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Who Qualifies?

- Progressive chronic illness which meets criteria based on disease type
  - CHF
  - COPD
  - Dementia
  - Frailty
- Financial Qualifications
  - Medicare Advantage - Senior HMO
  - Private Pay
  - Not funded by Medicare FFS

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Who Does Not Qualify?

- Patients pursuing traditional hospital management over aggressive home management of their chronic illness
- Patients too early in the disease progression not meeting criteria
- Patients not willing to participate in developing an advanced health care plan

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Transitions Four Pillars

1. Proactive In-Home Consultative Care
2. Evidence-Based Prognostication
3. Caregiver Support
4. Advance Care Planning

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1. Proactive In-Home Consultation

- Care management
- Minimizes unnecessary adverse events
- Respects patient's goals of care
- Guides patient through the continuum of their disease process

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1. Proactive In-Home Consultation

- Addresses total person – emotional, physical, spiritual
- Prepares patient/family for inevitable outcomes of disease process
- Team approach

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Transitions Team

- Registered Nurse
- MSW
- Spiritual Care
- Physician
- Advance Care Planning Specialist
- RN on call 24/7 for symptom management- use hospice after hours call system

2. Evidence-based Prognostication

- Identification of appropriate candidates
- Referrals from physicians, hospital teams, SNFs, and care management

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2. Evidence-based Prognostication

- Physicians overly optimistic by 530%
- Increases the risk that treatment decisions by patients, families and healthcare providers are NOT consistent with reality
- Leaves patients and families emotionally unready for inevitable outcomes
- Increase risk that providers will lose credibility

British Medical Journal; Extent and Determinants of Error in Doctors Prognoses in Terminally Ill patients; Prospective Cohort Study; Vol 320(7233), 19 Feb 2000 pp.469-473

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3. Caregiver Support

Hospice care is associated with an absolute reduction in death rates in the caregiver at 18 months post death of the patient of 0.5%

Nicholas Christakis, et al, *The Health Impact of Health care on families: a Matched Cohort Study of Hospice Use by Decedents and Mortality Outcomes in Surviving, Widowed Spouses,* Social Science and Medicine 2003, vol57 pp.465-475

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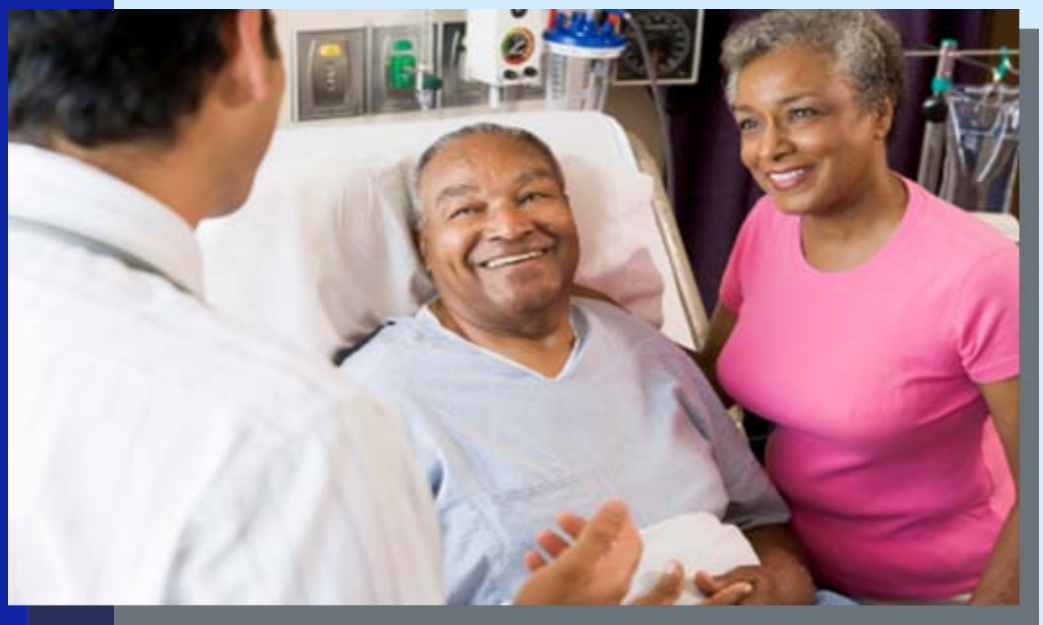
3. Caregiver support



- Home visits
- Family conferences
- Spiritual support
- Care plan including advanced health care planning

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4. Advance Health Care Planning

- Establish a “road map” of care
- Establish a plan for “when” not “if” adverse events occur
- Plan respects patient’s wishes to manage disease in the home, i.e. avoid hospitalizations
- Facilitates resolution of moral conflict

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Transitions Outcomes

- Growth of programs
- Cost effective care
- Decrease use of ED/Hospital
- Growth of hospice
- Earlier referrals to hospice

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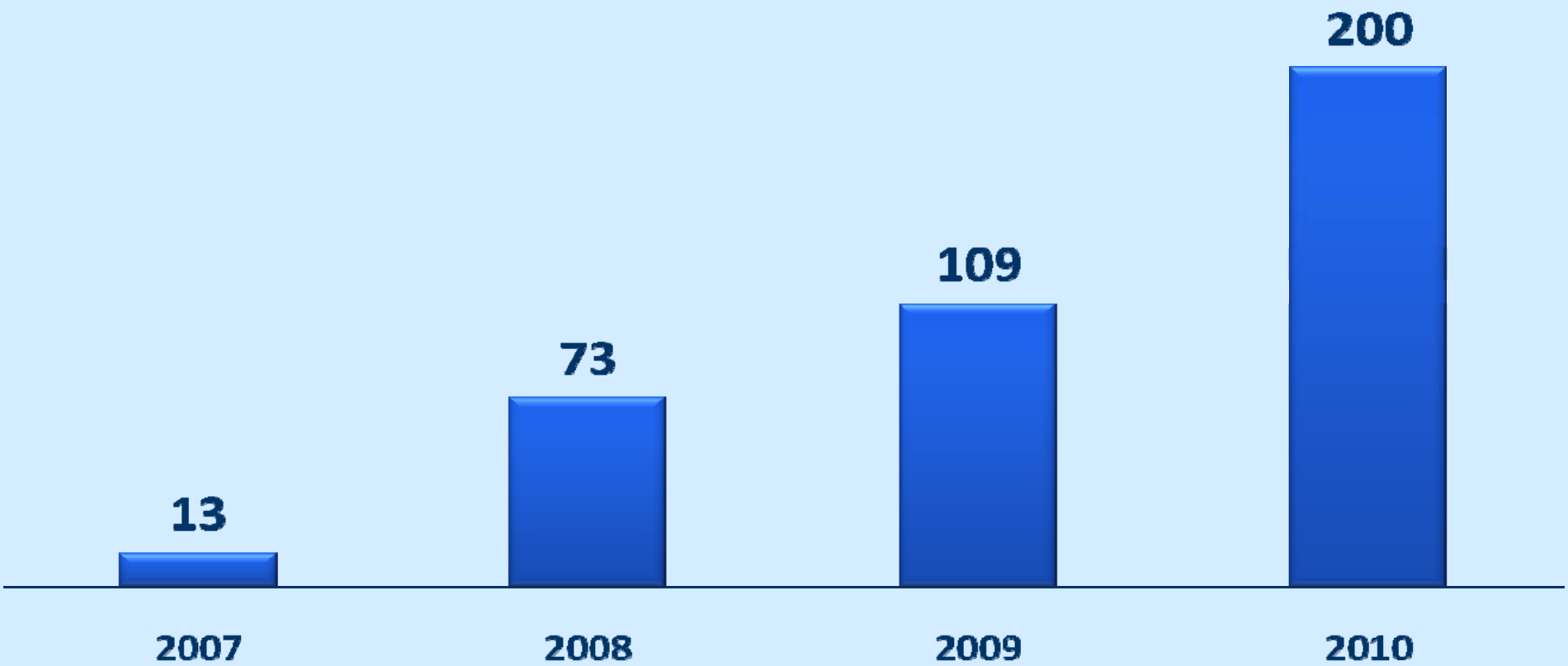
Transitions Admissions



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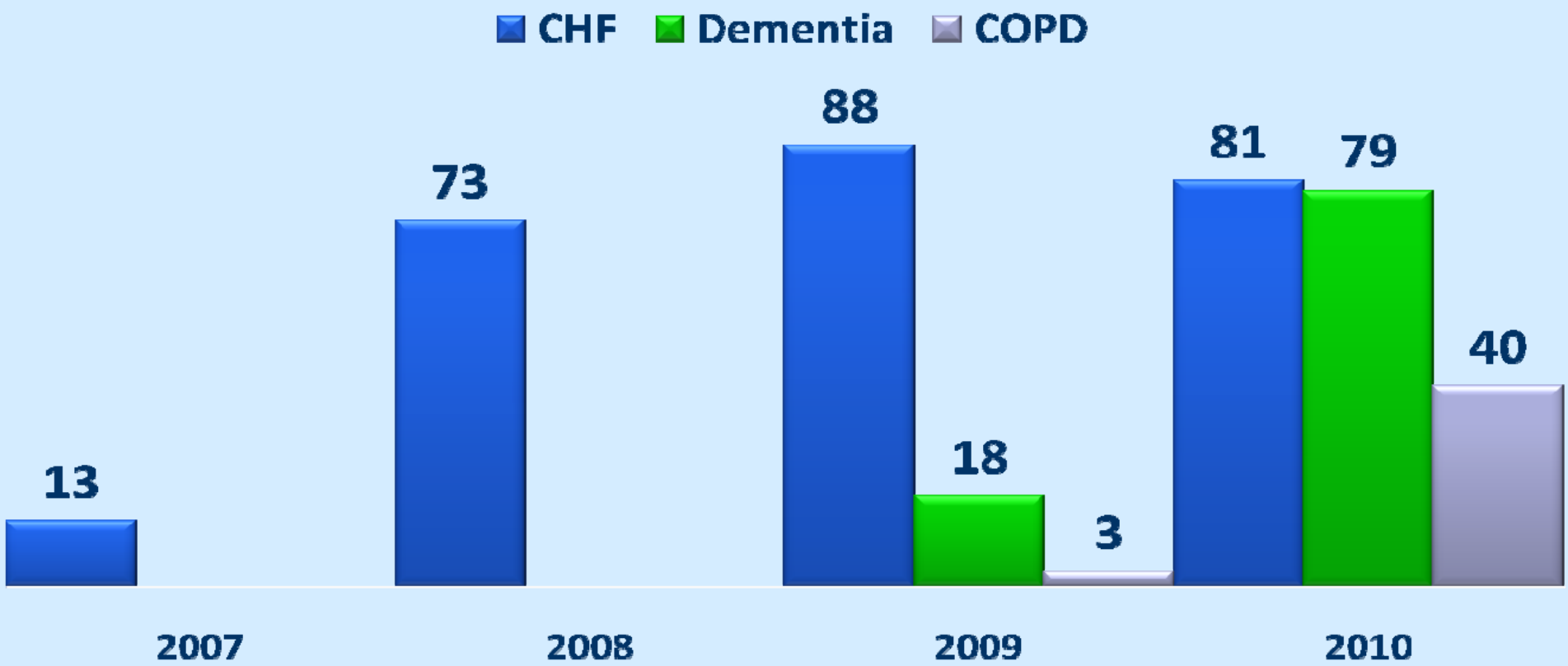
Transitions Admissions *by Dx*



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Cost Comparison

	FY '07	FY '08	FY '09
Pre-Transitions	$36,287.89	$561,752.83	$1,178,558.76
Transitions	$16,539.72	$236,401.35	$611,595.81
Cost Differential	**$19,748.17**	**$325,351.48**	**$566,962.95**

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ED/Hospitalizations

- Decrease **94%** disease-specific
- Decrease **56%** all cau

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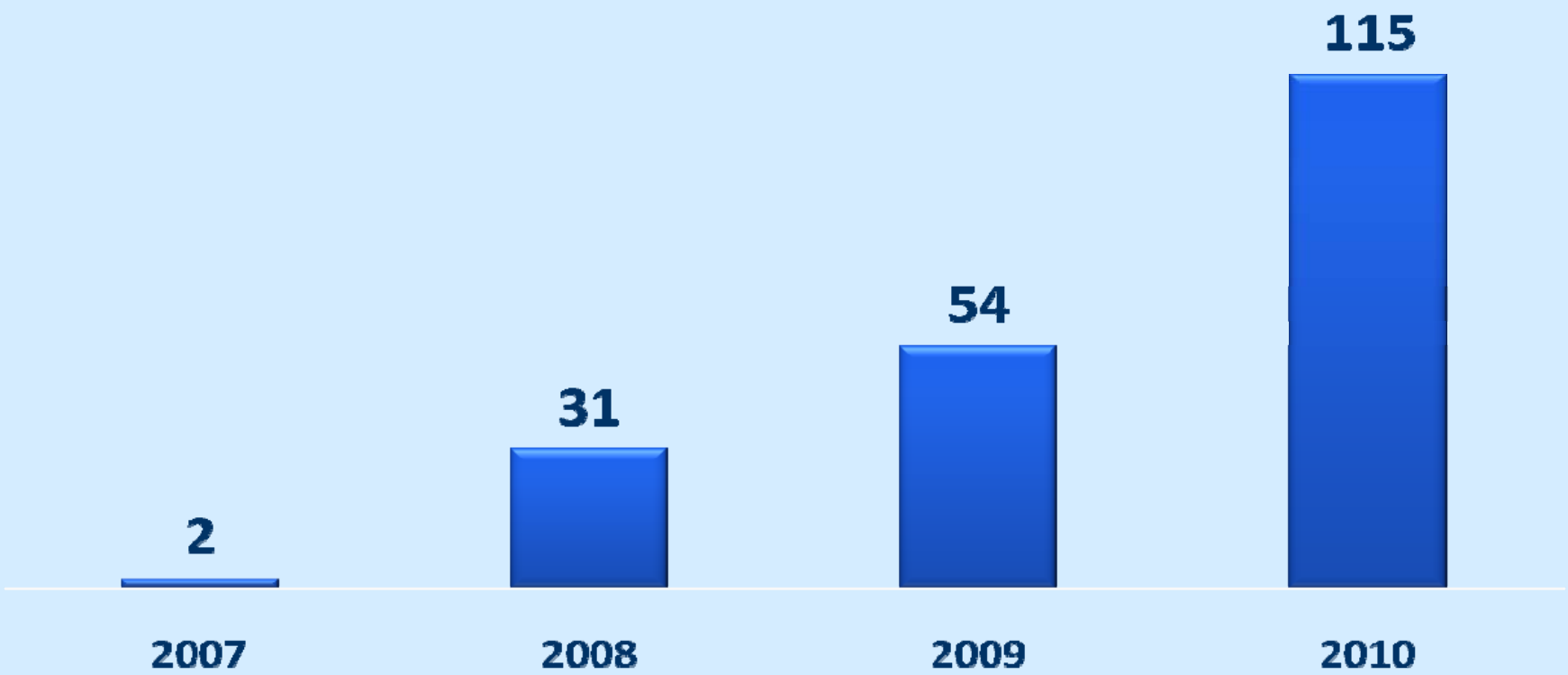
Transitions Transferred to Hospice



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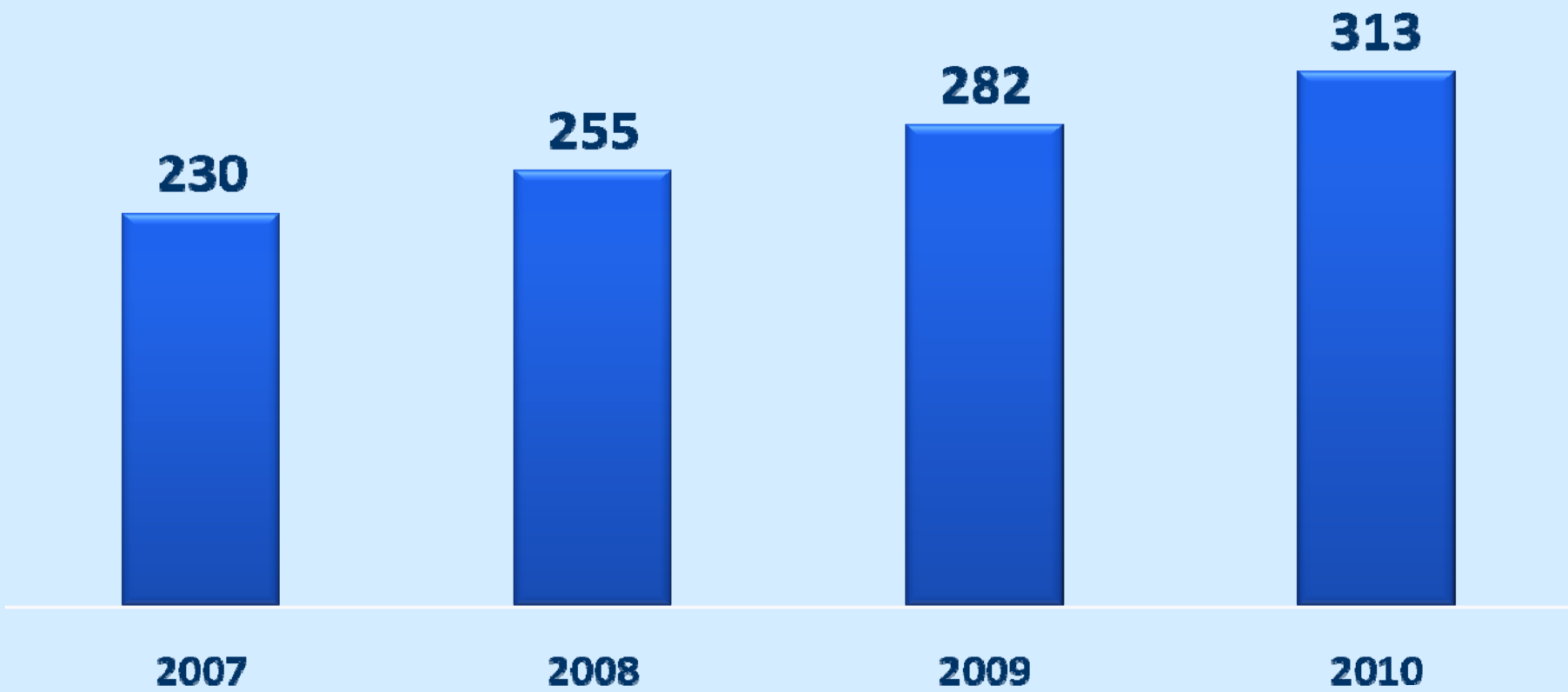
Hospice Average Daily Census



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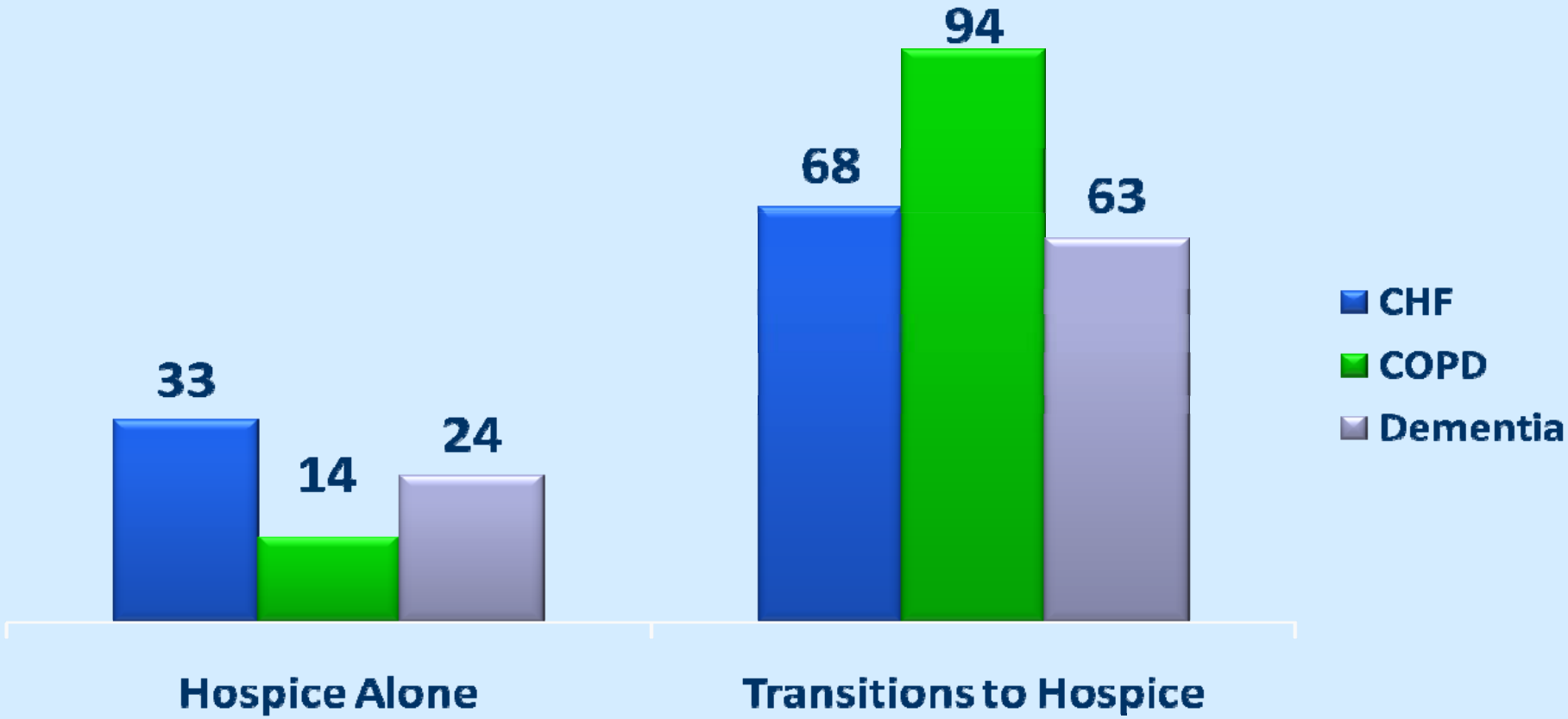
Median LOS in Hospice



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Transitions Moving Forward

2007 – Heart Failure

2009 – Dementia

2009 – COPD

2011 - Geriatric Frailty Syndrome

2012 – Oncology, Cirrhosis

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Transitions Summary

- Patients live longer and better
- Caregivers live better and survive
- Families are happier with care provided
- Specialists and PCPs continue to provide state-of-the-art care
- Care aligned with patient's goals of care
- Cost effective

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