Reducing Readmissions Through Palliative Care & Use of POLST

Southern California Patient Safety Collaborative

Track II—Care Transitions Learning and Action Network

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Palliative Care & the POLST Conversation

Key Objectives

- Identify 3 differences between POLST and Advance Health care directives.
- Identify 3 goals of the palliative care consult
- Identify 3 benefits to patients receiving palliative care
- Identify 3 benefits of palliative care for hospitals

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POLST Hallmarks

- Signed medical orders
- Addresses a range of life-sustaining interventions
- Allows for choosing treatment or foregoing treatment
- Brightly colored, clearly identifiable, standardized form across the State of California
- Is recognized and honored across all treatment settings

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POLST

Target population for POLST
- Chronic progressive disease
  - CHF, COPD, Dementia etc.
- Surprise statement (1 year)
  - " I would not be surprised if this patient died within the next year."

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Advance Directive vs. POLST

Advance Directive	POLST
For every adult	For the seriously ill
Requires decisions about myriad future treatments	Decision among presented options
Clear statement of preferences	Checking of preferred boxes
Needs to be retrieved	Stays with the patient
Requires interpretation	Actionable medical order

Fagerlin & Schneider. Enough: The Failure of the Living Will. Hastings Center Report 2004;34:30-42.

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POLST:
Physician Orders for Life-Sustaining Treatment

- – is a physician's order that outlines a plan of care reflecting the patient's wishes concerning care at life's end. The POLST form is voluntary and is intended to:
- Help you and your patient discuss and develop plans to reflect his or her wishes, and
- Assist physicians, nurses, health care facilities, and emergency personnel in honoring a person's wishes for life-sustaining treatment.

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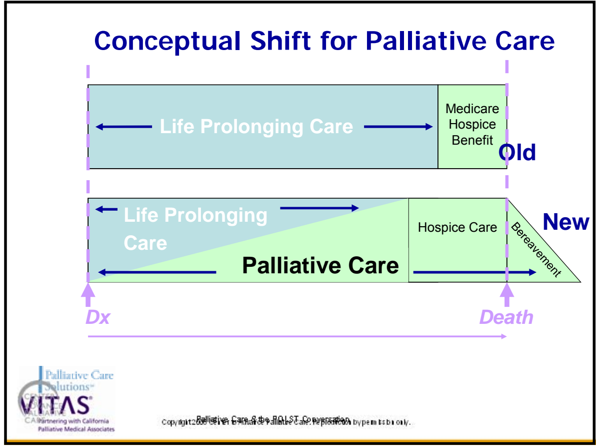
What is the POLST form?

- The POLST form is a bright pink form for medical orders. Your health care professional may use the POLST form to write orders that indicate what types of life-sustaining treatment you do or do not want if you become seriously ill.
- The POLST form asks for information about:
- Your preferences for resuscitation,
- Medical conditions,
- Use of antibiotics, and
- Artificially administered fluids and nutrition

"There's no easy way I can tell you this, so I'm sending you to someone who can."

What is Palliative Care?

- Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis.
- The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.
  - *Definition: Center to Advance Palliative Care*
    - » *www.capc.org*



How Does Palliative Care differ From Hospice?

- Non-hospice palliative care is appropriate at any point in a serious illness. It is provided at the same time as life-prolonging treatment. No prognostic requirement, no need to choose between treatment approaches.
- Hospice is a form of palliative care that provides care for those in the last weeks/few months of life. Patients must have a 2 MD-certified prognosis of <6 months + give up insurance coverage for curative/life prolonging treatment in order to be eligible. (Medicare Hospice Benefit: 84% Medicare, 5% Medicaid, 3% uninsured)

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Palliative Care Goals

- Treats ***pain*** and other ***symptoms***
- Facilitates ***time intensive*** patient / family communication
- Clarifies ***goals of care***
- Enables patients and families to make ***informed decisions***
- Supports the ***plan of care*** to maximize comfort at all stages of illness
- Can be provided while patients receive ***disease-modifying, curative treatment***
- Supports the referring physician by assisting with ***care coordination***

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Hospice vs. Palliative Care

Hospice	Palliative Care	Same or Different?
Relief from pain and symptoms	Relief from pain and symptoms	Same
Emotional and spiritual support available	Emotional and spiritual support available	Same
Six-month prognosis required	Six-month prognosis NOT required	Different
Curative care not covered	Curative care common	Different
DNR orders *usually* signed	Resuscitation pursued if desired	Different
Children rarely admit to hospice	Children commonly receive pall care	Different
Hospice interdisciplinary team ASSUMES total care of patient	Palliative care typically assumes a CONSULTATIVE role coordinating care from various health care providers	Different
Medicare Part A, Medicaid, Commercial Insurance	Medicare Part B, Medicaid, Commercial Insurance	Different

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Varying Roles of a Palliative Care Team

- Consultative service that offers recommendations to the referring physician
- Consultative service that offers recommendations to the referring physician and writes orders for medications / treatments as appropriate
- Physician's practice that assumes care for the patient
- Palliative care teams consist of varying combinations of these disciplines: MD / NP / SW / Chaplain

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Common Reasons Physicians Order Palliative Care Consultations for Patients

- Goals of Care Identification / Advance Care Planning
- Coordination of Care
- Manage Complex Pain / Symptoms
- Counseling / Emotional Support
- Spiritual Support
- Physician support with complex decision making
  - *(e.g. tube feeding, withdrawal of dialysis)*

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Common Settings for Consults

- Hospitals (adult & pediatric)
- LTCF
- ALF
- Private Residence
- Physician Practice (i.e., oncology practice)
- Dialysis Clinic
- Outpatient Clinic

Patient Benefits

- Pain / symptom management
- Counseling / emotional support/ Spiritual support
- Education, information and clarification of issues surrounding the disease process
- Goals of care identification (advance directives)
- Understanding of available, appropriate healthcare options
- Involvement in healthcare decisions - patient choice drives recommendations for plan of care revisions
- Ongoing communication, support and re-evaluation throughout illness
- Improved coordination of care and assistance with navigation among care settings

Referring Physician / Clinical Care Team Benefits

- Reduced time required for facilitation of family meetings and care coordination amongst providers and settings
- Expertise of pain and symptom management, particularly for complicated cases
- Improved patient outcomes
- Improved patient and family satisfaction

Hospital Benefits

- Systematic approach for supporting seriously ill patients
- Improved compliance with JCAHO accreditation quality standards
- More timely transfer of patients from acute to appropriate care settings
- Lowered costs - critical care, medication, treatment, lab
- Support for primary care physician or hospitalist and clinical care team
- Decreased ICU / hospital lengths of stay
- Decreased mortality rates
- Ease of staff burden and increased retention
- Increased patient and family satisfaction

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LTCF Benefits

- Assistance with pain and symptom management
- Palliative care training for LTC staff results in improved end of life care
- Assistance with thorough advance-care planning (CPR, nutrition, artificial hydration, hospitalization) avoids unnecessary and terminal hospitalizations
- Systematic approach to caring for 'high risk' residents
- Increased ability for residents to live last days in facility
- Ease of staff burden and increased retention
- Increased patient and family satisfaction

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Insurance Company Benefits

- Member access to palliative care specialists trained in pain and symptom management and facilitating goals of care discussions
- Increased member satisfaction
- Improved clinical outcomes
- Improved ability for members to make informed health care decisions
- Utilization management support (cost avoidance)

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Recognition

- **Hospice & Palliative Medicine**
  - *2006 - recognized by American Board of Medical Specialties (ABMS)*
  - *2007 - recognized by American Osteopathic Association (AOA)*
  - *2008 - first board exam offered by ABIM, >1400 examinees*
- **Certification also available for:**
  - *Nurse Practitioners*
  - *Registered Nurses*
  - *Licensed Clinical Social Workers*

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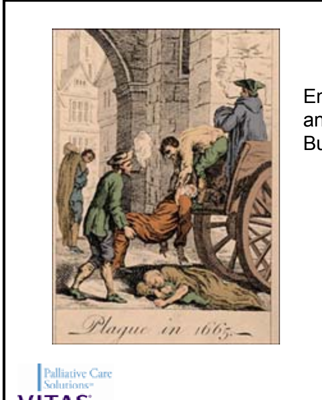

End of life care has improved and we've come along way, But still have a way to go.

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Accessibility and Resources

- **Michael J. Demoratz, PhD, LCSW., CCM**
  - *Palliative Care Administrator*
  - *California Palliative Medical Associates.*
  - *Direct – 949.355.6000*
  - *Main Line – 877.868-4827*
  - *michael.demoratz@vitas.com*
- *Resources*
  www.vitas.com VITAS Hospice
  www.capc.org Center to Advance Palliative Care
  www.capolst.org California POLST
  www.coalitionccc.org Coalition for Compassionate Care of California

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