Improving Continuity in End of Life Planning via Physicians Orders to Honor Patient Preferences: National Quality Forum’s Call for Community Action

John Carney, Vice President, Center for Practical Bioethics
Karin Porter-Williamson M.D., Medical Director and Section Leader for Palliative Care, Department of Internal Medicine, University of Kansas Medical Center

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TPOPP
Transportable Physician Orders for Patient Preferences

Providing Patients with respect and dignity by honoring their end-of-life wishes.
Objectives

1. Recognize the National Consensus Project Guidelines/National Quality Forum Preferred Practices for Hospice and Palliative Care Quality

2. Understand the shared ownership we have as a community of practitioners for providing quality and continuity in end of life care planning.
Objectives

3. Identify key elements of successful community adoption of a Physician Orders for Life Sustaining Treatment (POLST) paradigm - KC initiative, called TPOPP

4. Distinguish appropriate patient populations for whom POLST paradigm is targeted and care planning steps necessary to resolve questions about various interventions addressed in form.
Focus on Quality in Palliative Care

The National Consensus Project, 2001-2004

- American Academy for Hospice and Palliative Medicine,
- Center to Advance Palliative Care
- Hospice and Palliative Nurses Association
- Last Acts Partnership
- National Hospice and Palliative Care Organization

Goals

- Define domains and elements of quality palliative care
- Provide structure for standardization of services

Outcomes

- Clinical Practice Guidelines for Quality Palliative Care, 2004
NCP Guidelines

8 Domains

- Structure and Processes of Care
- Physical Aspects of Care
- Psychological Aspects of Care
- Social Aspects of Care
- Spiritual, Religious, and Existential Aspects of Care
- Cultural Aspects of Care
- Care of the Imminently Dying Patient
- Ethical and Legal Aspects of Care
Focus on Quality in Palliative Care

- NCP guidelines used as framework for the National Quality Forum’s *Preferred Practices for Palliative and Hospice Care Quality*

- CMS derives its quality indicators and outcome measures from NQF products
Why are Preferred Practices Important?

- Provide framework
  - To build quality Palliative Care services in a standardized way
  - To formulate quality outcomes
    - Allows measurement and study for process improvement/evolution of the field
- They will eventually translate into reimbursement requirements
- It’s the right thing to do for patients
NQF Preferred Practices Domain 8: Legal and Ethical Aspects

- **Preferred Practice 32:** Document Surrogate/decision maker for every patient in acute, long term, palliative and hospice care

- **PP 33:** Document preferences for Goals of Care, treatment options, and setting of care

- **PP 34:** Convert the treatment goals into medical orders, ensure that information is transferable and applicable across care settings through a program such as the POLST (Physician Orders for Life Sustaining Treatment) paradigm

- **PP 35:** Make advance directives and surrogacy designations available across settings, while protecting patient privacy - example internet based registries or EMR

- **PP 36:** Develop community collaborations to promote advance care planning and completion of advance directives
So What is POLST (T-POPP)?

- A transportable physician order set
  - Moves with the patient
  - Defines emergency interventions that the patient would or would not wish to happen in the event of rapidly deteriorating health
  - Follows a POLST paradigm model
    - most widely studied out of hospital DNAR order in the nation
Required Elements of a POLST Paradigm

Why core elements?

• A POLST Paradigm is a type of clinical intervention.

• Certain elements are essential in order for the system to be effectively replicated.
There are 9 required elements

1. **Form constitutes medical orders.** Must be followed by health professionals who provide care across the continuum of care (Requires a signature of physician or other licensed HP and date/time.)

2. **Form is standardized in format, color, and wording.**
9 required elements (continued)

3. Form is primarily used for patients with advanced, progressive chronic illness
   - Those patients where answer to the question “Would it surprise me if this patient were to die in the next 12 months? ” is NO
   - Patients with capacity who wish to further define preferences beyond (and in addition to) advance directives (they are additive)

4. Form may be used to limit treatment or to express the desire for full treatment
5. **Form provides clear direction about the desired response if the patient is pulseless and apneic.**

6. **Form allows for clear directions about other life-sustaining treatment if:**
   - patient has serious cardiac or pulmonary problems
   - expresses instructions regarding medically administered fluids, nutrition and antibiotics
7. Form transfers with the patient
8. Health professionals are trained to use the form and to have discussions to complete the form.
9. Measures are made to monitor the success of the program and its implementation
<table>
<thead>
<tr>
<th>Section A</th>
<th>Transportable Physician Orders for Patient Preference (TPOPP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>this physician order is based on the patient's resident's preferences. Each section is completed by the resident's primary attending physician.</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name/Initial/Last Name/Initial</td>
</tr>
<tr>
<td>Title</td>
<td>Title of Patient/Resident</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B</th>
<th>CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check one box only</td>
<td>Do Not Attempt Resuscitation (DNR)/no CPR/Do Not Attempt CPR/Do Not Resuscitate (DNR)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section C</th>
<th>MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check one box only</td>
<td>Comfort Measures only. Treat with dignity and respect. Keep clean, warm, and dry. Use medications by any route, providing medical care and pain relief. Pain and suffering. Use expired, outdated and damaged medication.</td>
</tr>
</tbody>
</table>

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<tr>
<th>Section D</th>
<th>MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Oral fluid and nutrition always.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check one box only</td>
<td>Oral fluid and nutrition always.</td>
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</tbody>
</table>

<table>
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<tr>
<th>Section E</th>
<th>Other Instructions:</th>
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<tr>
<th>Section F</th>
<th>Other Instructions:</th>
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<tr>
<th>Section G</th>
<th>Other Instructions:</th>
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DRAFT version May 2008 Updated 5/08
This form should be reviewed if there is substantial change in patient's health status or prior to any change in treatment preferences. This form must be reviewed if the patient resides in transferred from one health care setting to another.

If this form is to be voided, please sign "VOID" in large letters at the front of the form. After voiding the form, please return it to the appropriate physician or care provider.

Section 6

Review Section

This section documents completion of patient preferences and changes in what is reflected in physician orders.

Review Date

Print Reviewer's Name

File and Organization

Signature

Location of Review

Outcome of Review

- FORM Completed - No change
- FORM UPDATED - no update from
- FORM UPDATED - No Change
- FORM UPDATED - No Change
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*FORM SHALL ACCOMPANY PATIENT/PATIENT'S REVISED TRANSFER PERIOD OR DISCHARGE*
Callout sections highlight specific elements of TPOPP form for use in training consumers, EMS, long term care, hospital, home care, hospice and other healthcare providers.
Why not just use Advance Directives?
Living Will* VS. T-POPP

For every adult
- Defines preferences about treatment if in a future state of illness
- Statement of patient preference (directive)
- Needs to be retrieved (bank box, POA)
- Requires interpretation about the future

For the seriously ill
- Defines preferences for treatment in the current state of illness
- Physician order to be followed
- Stays with the patient across all care venues
- Prepares for immediate action in the present

What is the scope of this issue?

- 2 million deaths in the U.S per year
  - 50% of them happen in the hospital
  - 25% of them happen in a nursing facility
  - >70% of people indicate that they would rather NOT die in the hospital
    - Without a plan for the crash, they get terminally hospitalized
- Population aging, this issue is growing exponentially
Data on POLST outcomes

- Prospective study, N=180 nursing home residents, POLST paradigm
  - Only 13% hospitalized in a one year period
  - Only 2 of 38 patients who died were in the hospital
  - No ICU admissions
  - High family satisfaction regarding how their loved one’s were treated

Data on POLST outcomes

- Retrospective review of all deaths 1997 PACE program in OR (58 deaths)
  - POLST completion in ElderPlace exceeded reported advance directive rates
  - Care matched POLST instructions for CPR, antibiotics, IV fluids, and feeding tubes more consistently than previously reported for advance directive instructions

Data on POLST outcomes

- Increased congruence in patient wishes and actualized care plan
- Better delineation of patient specific wishes
  - Of those patients who chose DNR:
    - 33% opted comfort measures only
    - 77% opted for other interventions (DNR does not mean Do Not Respond)

Data on POLST outcomes

- Survey of >572 EMS responders in Oregon
  - 93% felt POLST was useful to their understanding of resuscitation status
  - 80% expressed a wish that more patients use POLST forms
  - Felt that the form changed their plan of emergency care for the patient in 45% of the cases
  - Articles available electronically

National Push for POLST paradigms

Many stakeholders agree that Advanced Care Planning needs to move in this direction:

1. National Quality Forum
2. The Joint Commission
3. American Heart Association: International Consensus Conference on CPR and Emergency Cardiovascular Care

- Specific advocacy for POLST paradigms
- Circulation 2005;112;III-100-III-108
How will TPOPP help:
Clinical framework for goals discussions

- With paradigm:
  - Tie Patient Care Goals to Orders
  - Clarifies Types of Orders
  - Reduce risk of ineffective or harmful treatment
  - **Requires** provider-patient/surrogate conversations
How will TPOPP help: Communication in EOL Care

- Acknowledgement of personal preferences
- Shared knowledge about prognosis
- Elucidation of goals of care
- Implementing a management plan
- The importance of truth-telling
How will TPOPP help: Facilitate Patients’ Preferences

- Ethical principle of autonomy supports self-determination.

- Personal preferences should be respected in a person with capacity to communicate and decide.

- Implemented for incapacitated person through previously expressed values, conversations and advance care directives.

- Person may be represented by legitimate proxy decision makers.
How will TPOPP help: Administrative/Access Issues

- Hospital Admissions and ER "Bounce backs" – Boomerangs
- Advance Care planning at the time of LTC admission
- Ethical Dimensions in Discharge – Sicker/Quicker; Environment transitions and handoffs
- Honoring Out of Hospital *Do Not* Orders
How will TPOPP help:
Better Care Plan Management

- Include Personal Preferences
  - Support good decision making process
    - Information
    - Control
    - Autonomy

- Goals of Care – Integrate Quality of Life

- Prognosis and illness staging
  - Especially with chronic disease and advanced age
  - Co-morbidities

- Determine impact of burden and benefit; care-giving and family decision making

- Recognize the reality of managing death
How will TPOPP help:
Facilitate preferred practices

- Fits a POLST paradigm structure called for by NQF
- Addresses acute response to chronic decline
  - Advanced treatments for frail elderly
  - Meaningful alternatives based on preferences
- Identifies current deficits in care planning
  - Provides structure for more comprehensive decision making
- Provides tools for trial and implementation
- Calls for community collaboration and integration of systems
Benefits Across Settings

1. Facilitates communication
   - Patient choices should **not** be nullified by changes in setting of care – informational continuity.
   - Removes HIPAA threat to vital communication.
   - Starts with any setting: hospital- home care- hospice- nursing home
   - TPOPP best represents preferences regarding end of life care.
Benefits Across Settings

2. Facilitates mandated joint care plans for hospice patients in nursing homes
   - Will require state and provider commitment
   - Supports explicit communication with all relevant parties and promotes accountability by mutually dividing responsibility for elements of the care plan
KC Initiative and Regulatory/Legal Issues

- Examine state regulations or need for legislation
  - Legislative approach (WV, TN, HI)
  - Regulatory approach (OR, UT, WA)
  - Hybrid approach (NY)

- Patient’s/legal agent’s signature
  - Mandatory or optional
  - Surrogate limits

- Practitioner’s Signature other than MD
  - Need for legislation, potential opposition
  - Acceptable policies & procedures with current regulations

- Both states (MO/KS) have OHDNR legislation
- Neither state (MO/KS) has surrogacy law
Kansas City TPOPP Paradigm Effort

- Identify Stakeholders
- Establish Steering Group
- Outline Work Plan (4 Work Groups formed)
- Vet ideas and suggestions
- Tie to current issues (OHDNRs in MO and KS)
- Secure area wide commitments during training
- Set early 2009 launch date
- Study and/or research impact
System-Wide Approach

- Different Settings acknowledge form
  - Hospital
  - Nursing Home
  - Home
  - Ambulance

- Uniform Response
  - Document that indicates specific responses to various likely complications

- Avoidance of “Error”
  - Failure of planned action to be completed as indicated
TPOPP Contact Information

- **John G. Carney**  
  Vice President for Aging and End of Life  
  Center for Practical Bioethics  
  1111 Main, Suite 500  
  Kansas City, MO 64118  
  jcarney@practicalbioethics.org  
  816.221.1100 ext 220

- **Karin Porter-Williamson, MD**  
  Medical Director and Section Leader for Palliative Care  
  Department of Internal Medicine  
  University of Kansas Medical Center  
  5026 Wescoe Mailstop 1020  
  3901 Rainbow Blvd.  
  Kansas City, KS 66160  
  Kporter-williamson@kumc.edu  
  913.588.6063