South Carolina Coalition for Care of the Seriously Ill (CSI)
Uniform Processes to Improve Consent, Communication, and Decision Making in South Carolina Hospitals

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Case for Improved Communication, Consent and Decision-making

- Experience with hospital ethics committees in South Carolina, communication problems are frequently the beginning of disputes with patients and families.

  - Burdensome transitions are common, vary according to state, and are associated with markers of poor quality in end-of-life care.
  - Ultimately, a decline in burdensome transitions will come about through a combination of:
    - Improved provider incentives, and
    - Decision making that elicits and respects the needs of the choices of the patients.

  - Change financial incentives to hospitalize a patient from a nursing home.
  - Improve acute care in nursing homes, including communication strategies.
State Variations in the Proportion of Nursing Home Residents with Advanced Cognitive Impairment Who Had at Least One Burdensome Transition.

Case for Improved Communication, Consent and Decision-making, p.2

- Patient and Family Surveys, including the SUPPORT study.
- Physicians speak out:
- Proposed solutions:
  - Physicians should take more time to communicate better.
  - Medical schools should improve how they teach communication.
  - Medicare, Medicaid, and health insurance companies should reimburse physicians better for the time and effort spent in communication.
  - Academic medical centers could apply the science of quality improvement to analyze “communication errors” and develop quality improvement plans.
Determining the Patient’s Treatment Plan is Difficult


- “An 80 year old patient has dementia and pneumonia (twice recently). Speech therapist says p.o. feeding is unsafe. There’s no reversibility to swallowing problem. You are called to place PEG. Family says we don’t want any feeding of patient - we don’t want to prolong his life. But the patient isn’t in any terrible pain at all and isn’t just lying there staring at the ceiling. He can interact. He can recognize and name his wife. He can’t solve quadratic equations. But he has some ability to interact.
Determining the Patient’s Treatment Plan is Difficult

- His prior wishes aren’t written down and are a little vague. Does anyone have a problem with withholding nutrition completely?
- 239 replies, including
  - “Find out what he wants and see if the family will agree.”
  - “Do what the family wants.”
  - “What part of swallowing is impaired? One could use slurry or thickened fluids.”
  - “The patient’s wish to get fed by PEG, if that is his wish, should get priority.”
  - “A PEG tube is better than choking to death.”
SC Statutory Advance Directives

- **Health Care Power of Attorney** (SC Code of Laws Title 62 Chapter 5) allows you to designate someone to make all health care decisions for you when you temporarily or permanently cannot make them for yourself.

- **Living Will** (SC Code of Laws Title 44 Chapter 77) also known as the Declaration of Desire for a Natural Death, this form allows you to express your choices about your care ONLY if you are terminally ill or permanently unconscious.
  - The Five Wishes document allows you to communicate your wishes to your family, friends and healthcare providers including decisions about medical treatments you may elect to receive or decline, what you want your loved ones to know about your health and who you would want to make sure your wishes are followed.

- **EMS Do Not Resuscitate order**
List Three Shortcomings of South Carolina Statutory Advance Directives.

1. The Declaration of Desire for a Natural Death, while suited to allow a person to guide the physicians in the event prolonged coma, does not adequately address the many unforeseen decisions that hospitalized seriously ill patients and their families are asked to make prior to the time when death is imminent.

2. The Declaration of Desire for a Natural Death is confused with a request for Do Not Resuscitate for a seriously ill person in the hospital for whom CPR is not helpful or desired but for whom death is not imminent.

3. The Declaration of Desire for a Natural Death does not adequately address the decisions of a seriously ill person at home or in a nursing facility to either be taken to the hospital or not.

4. The Declaration of Desire for a Natural Death is frequently not with the patient at the time of critical decisions.
List Three Approaches to Improve Consent, Communication, and Decision Making in South Carolina

1. Greater use of Advance Care Planning in the community.
3. Greater use of inpatient palliative care consultation services.
4. Use of POLST across the state.
5. Improved communication for seriously ill hospital patients at admission.
South Carolina Coalition for Care of the Seriously Ill

- The SC Coalition for the Care of the Seriously Ill (SC Coalition CSI) is comprised of clinical and administrative leaders representing key statewide organizational partners, healthcare entities, and individuals that have agreed to collaborate in a major statewide initiative to redesign care, improve quality of life, and protect the ethical rights of the seriously, chronically, or terminally ill in S.C.

- Members of the Coalition for 2010 include:
  - South Carolina Medical Association
  - The Carolinas Center for Hospice and End of Life Care
  - the South Carolina Hospital Association
  - the SC Healthcare Ethics Network
  - The S.C. Society of Chaplains
  - LifePoint
  - AARP
  - South Carolina Nurses Association
South Carolina Coalition for Care of the Seriously Ill - Charter

- **Vision Statement**: SC delivers excellent communication and shared decision-making for persons with serious, chronic, or terminal illnesses.

- **Mission Statement**: All persons in SC with serious, chronic, or terminal illnesses will have an active voice in the care decision process.

- The Coalition will set the vision, mission, and strategic aims and will provide guidance and monitor the impact and value of its work.

- It will also seek grant funding to accomplish the strategic aims and promote alignment of public policy with the Coalition’s mission.
What is POLST?

- A physician order
- Signed by the patient
- After consultation with the physician
- Facilitated by a person trained in advance care planning
- Directed toward people with serious, chronic illness such that death in the next year would not be a surprise
- Addressing the decision at a moment of medical crisis to
  - 1) Hospitalize with full therapeutic intervention,
  - 2) Hospitalize with limited therapeutic intervention (such as no CPR), or
  - 3) Provide supportive, palliative care in the present setting (home or nursing facility)
What is POLST?

- g. addressing further decisions such as feeding tube, parenteral (IV) hydration, or antibiotics
- h. documented in a widely publicized, recognized and understood form with a distinct pink color
- i. accepted by EMS responders, hospices, nursing facilities, and hospitals across the state
# Oregon POLST Form

**Physician Orders for Life-Sustaining Treatment (POLST)**

**A.** Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing.
- [ ] Attempt Resuscitation/CPR
- [ ] Do Not Attempt Resuscitation/DNR (A Will Natural Death)

**B.** Medical Interventions: Person has pulse and is breathing.
- [ ] Comfort Measures Only
- [ ] Limited Interventions
- [ ] Full Treatment

**C.** Antibiotics
- [ ] No antibiotics
- [ ] Use antibiotics

**D.** Artificially Administered Nutrition: Always give by mouth if feasible.
- [ ] No artificial nutrition by tube
- [ ] Long-term artificial nutrition by tube

**E.** Reason for Orders and Signatures
- [ ] DO NOT ORDER LIFE-SUSTAINING TREATMENT: Patient’s health condition is such that it is not in the patient’s best interest to provide life-sustaining treatment.
- [ ] ORDER LIFE-SUSTAINING TREATMENT: Patient’s health condition is such that it is in the patient’s best interest to provide life-sustaining treatment.

**Contact Information**
- Name: ____________________________
- Phone Number: ____________________

**Health Care Professionals, Prescribing Form (optional)**
- Program Title: ____________________
- Phone Number: ____________________

**PAS Supporting Physician**
- Name: ____________________________
- Phone Number: ____________________

**Directions for Health Care Professionals**

**Completing POLST**
- Should reflect current preferences of patients with advanced illness or end of life care.
- Written orders are acceptable if signed by physician.

**Sending to POLST Registry**
- Required unless “Opt Out” box is checked.
- Person’s full name
- Date of birth
- Address
- Phone number
- Signature

**Revising POLST**
- This POLST should be reviewed periodically.
  - Three to six months
  - Change in patient’s condition
  - Change in patient’s treatment goals
  - Change in patient’s priorities

**Validating POLST**
- A patient with capacity, or the patient’s representative, can validate the POLST form and request elective treatment.
- The patient or the patient’s legal representative can validate the POLST form and request elective treatment.

**Register ID Sticker Here:**

**Additional Information**
- For more information, please visit the Oregon POLST website at [www.oregonpolst.org](http://www.oregonpolst.org).

**Oregon Health Authority:**
- For training and updates, please visit [www.oregonpolst.org](http://www.oregonpolst.org).
SECTION B

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

☐ 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. Patient prefers no transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.

☐ Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care.

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

Additional Orders: ____________________________
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

**Physician Orders for Life-Sustaining Treatment (POLST)**

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. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

**A**

**CARDIOPULMONARY RESUSCITATION (CPR):**  
If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.

- [ ] Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- [ ] Do Not Attempt Resuscitation/DNR  (Allow Natural Death)

**B**

**MEDICAL INTERVENTIONS:**  
If person has pulse and/or is breathing.

- [ ] Comfort Measures Only  Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Transfer to hospital only if comfort needs cannot be met in current location.*
- [ ] Limited Additional Interventions  In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. *Transfer to hospital only if comfort needs cannot be met in current location.*
- [ ] Full Treatment  In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.*

**Additional Orders:**

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Patient Last Name: ____________________________  Date Form Prepared: ____________________________

Patient First Name: ____________________________  Patient Date of Birth: ____________________________

Patient Middle Name: ____________________________  Medical Record #: (optional)
**Artificially Administered Nutrition:** Offer food by mouth if feasible and desired.

<table>
<thead>
<tr>
<th>Check One</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No artificial means of nutrition, including feeding tubes. Additional Orders:</td>
</tr>
<tr>
<td>☐ Trial period of artificial nutrition, including feeding tubes.</td>
</tr>
<tr>
<td>☐ Long-term artificial nutrition, including feeding tubes.</td>
</tr>
</tbody>
</table>

**Information and Signatures:**

- **Discussed with:**
  - ☐ Patient (Patient Has Capacity)
  - ☐ Legally Recognized Decisionmaker

- **Advance Directive:**
  - ☐ Advance Directive dated ______ available and reviewed → Health Care Agent if named in Advance Directive:
  - ☐ Advance Directive not available
  - ☐ No Advance Directive

**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:**
- **Physician License Number:**

**Physician Signature:** (required)

**Date:**

**Signature of Patient or Legally Recognized Decisionmaker**

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.

- **Print Name:**
- **Relationship:** (write self if patient)

- **Signature:** (required)

- **Date:**

- **Address:**
- **Daytime Phone Number:**
- **Evening Phone Number:**

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
How Advance Directives and POLST Work Together

- Age 18
  - Complete an Advance Directive
- Update Advance Directive Periodically
- Diagnosed with Advanced Illness or Frailty *(at any age)*
- Complete a POLST Form
- Change in health status
- May Complete a new POLST Form
  - Treatment Wishes Honored
Designation of POLST Paradigm Program status based on information available by the program to the Task Force.
In North Carolina, POLST is MOST

- A Medical Order for Scope of Treatment, called a MOST form, like a Portable DNR Order, is a medical order that can be followed in different settings such as in the home, nursing home, hospital, etc. A MOST form contains instructions for CPR and also addresses other end-of-life treatments that you may or may not want to receive. For example, a MOST can tell emergency medical responders and other health care providers what level of treatment you would like to receive, whether you would like to receive antibiotics, and artificial nutrition and hydration through tubes.
In North Carolina, POLST is MOST

While a MOST is a medical order that must be signed by your physician (or physician assistant or nurse practitioner), it also must be signed by you or, if you are not able to make or communicate your health care decisions, by someone who is legally recognized to speak for you. A MOST can be cancelled by destroying the original form or indicating on the form that it is void. A MOST form must be obtained from your physician. For more information, be sure to talk to your physician or other health care provider.
POST Pilot Project in 2012

- Authorized by DHEC under EMS DNR statute
- Limited time: less than a year
- Limited geography: Charleston, Greenville, & Spartanburg
- Encouragement and support of the South Carolina Coalition for the Seriously Ill, including the SCMA and SCHA
- Need to collaborate with hospital systems, hospices, and nursing facilities.
- POST document is under preparation by SC Coalition for CSI.
- Hospital(s) need to train people to undertake the POST interview with candidates for POST, that is people with chronic, serious illness such that “death within a year would not be a surprise.”
Pilot Project Initial Steps

- Establish commitment of the hospital system.
- Learn from POLST national organization.
- Learn from Roper St. Francis.
- Coordinate with other hospital system, Greenville City, Greenville County, EMS providers, SNF providers, and hospice providers.
- Consider collaboration with foundations, corporate partners, educational facilities.
- Plan outreach to churches, senior organizations, television, radio, and newspaper.
- Physician education with emphasis on hospitalists, ER physicians, hospice physicians, and SNF physicians.
OHSU Epic EHR Snapshot

Verification of, and hyperlink to POLST document scans are available throughout the entirety of the EHR via the Patient Identification Bar.

Direct access to the POLST document scans are available via hyperlink on patient care "Snapshot".

The dating of the POLST documents electronically allows users to review the frequency of new or modified documentation, with the most recent first in view.
“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
Communication Review of Systems (C-ROS)

- A clinical tool
- Part of the History and Physical Exam with Present Illness, Past History, Family History, Social History, (physical) Review of Systems
- Completed by the physician, like the H&P, when a patient is admitted to the hospital
- The admitting physician may get help from the multidisciplinary team.
Communication Review of Systems (C-ROS)

1. Ability to Consent
2. Patient Voice
3. Physician Voice
4. Patient Understanding
5. Physician Understanding
6. Advance Directives
7. Decisions
The C-ROS is a communication checklist. It needs to be studied and tested like any other checklist or quality improvement process.

The C-ROS is simple, inexpensive, and intuitive.

How to administer the C-ROS:

- Start with “For medical issues, who would you want to speak for you if you could not speak for yourself?”
- Ask “Do you have a Healthcare Power of Attorney?” Then explain what it is, etc.
Why will the C-ROS help with Communication, Consent and Decision-Making in hospitals in SC?

- The Communication Review of Systems is a *uniform process*.
- A *uniform process* can change the medical culture for:
  - Physicians and others in a hospital system
  - Hospitals across the state
  - Physicians and others over the continuum of training
    - Medical school
    - Postgraduate training
    - In practice
  - Patients at various times, with various physicians, at various hospitals, under various circumstances.
Summary

There is an opportunity to improve consent, communication, and decision-making for seriously ill patients in South Carolina hospitals with:

- Greater use of Healthcare Power of Attorney
- Implementation of POLST paradigm in South Carolina
- Uniform processes across the state for patients admitted to the hospital, such as the uniform documentation template, the Communication Review of Systems (C-ROS), and the ICU bundle
- Greater use of palliative care consultation
What Is Palliative Care?

Medical treatment that aims to relieve suffering and improve quality of life *simultaneously with all other appropriate treatment* for patients with advanced illness, and their families.
Domains of Palliative Care

- Communication, help with medical decision-making
- Expert symptom assessment and treatment
- Psychosocial and practical support, care coordination, and bereavement services
# Stages in the Continuum of Palliative Care

<table>
<thead>
<tr>
<th></th>
<th>Curative Care</th>
<th>Active Palliative</th>
<th>Symptomatic Palliative</th>
<th>Supportive Palliative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Goal</strong></td>
<td>Cure</td>
<td>Prolong life/</td>
<td>Comfort</td>
<td>Comfort</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Survive</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disease Goal</strong></td>
<td>Eliminate</td>
<td>Arrest/</td>
<td>Some Control</td>
<td>No Control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mind Set</strong></td>
<td>Win</td>
<td>Fight</td>
<td>Hope/Live with it</td>
<td>Acceptance</td>
</tr>
<tr>
<td><strong>CPR Appropriate?</strong></td>
<td>Yes</td>
<td>Probably</td>
<td>Varies</td>
<td>No</td>
</tr>
<tr>
<td><strong>Hospice Appropriate?</strong></td>
<td>No</td>
<td>No</td>
<td>Maybe</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The Center to Advance Palliative Care (CAPC)

Provides health care professionals with the tools, training and technical assistance necessary to start and sustain successful palliative care programs in hospitals and other health care settings.

CAPC is a national organization dedicated to increasing the availability of quality palliative care services for people facing serious illness. [www.capc.org](http://www.capc.org)

Director: Diane E. Meier, MD, FACP
References

www.POLST.org