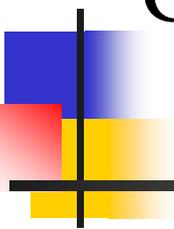


South Carolina Coalition for Care of the Seriously Ill (CSI)

Uniform Processes to Improve Consent,
Communication, and Decision Making in South
Carolina Hospitals



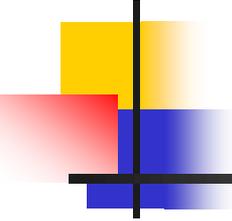
Fifth Annual Patient Safety Symposium

April 26, 2012

John C. Ropp, M.D., Hartsville, SC

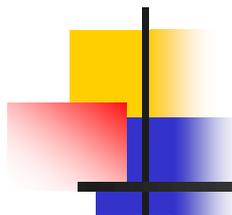
Mark A. O'Rourke, M.D., Greenville, SC

R. Scott Lake, M.D., Charleston, SC



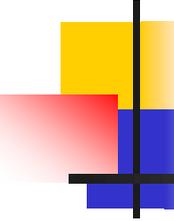
SC Statutory Advance Directives

- **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**



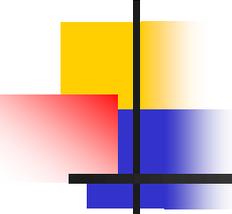
List Three Shortcomings of South Carolina Statutory Advance Directives.

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.



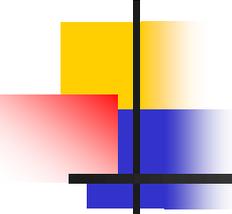
List Three Approaches to Improve Consent, Communication, and Decision Making in South Carolina

1. Greater use of Advance Care Planning in the community.
2. Greater use of Healthcare Power of Attorney, encouraged by physicians.
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.



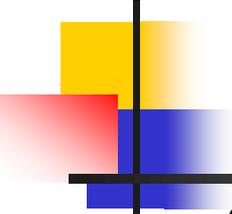
South Carolina Coalition for Care of the Seriously Ill

- 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



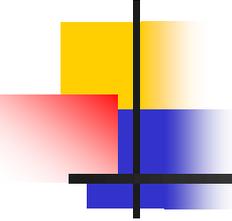
South Carolina Coalition for Care of the Seriously Ill - Charter

- **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
 - hospitalize with full therapeutic intervention,
 - hospitalize with limited therapeutic intervention (such as no CPR), or
 - provide supportive, palliative care in the present setting (home or nursing facility)

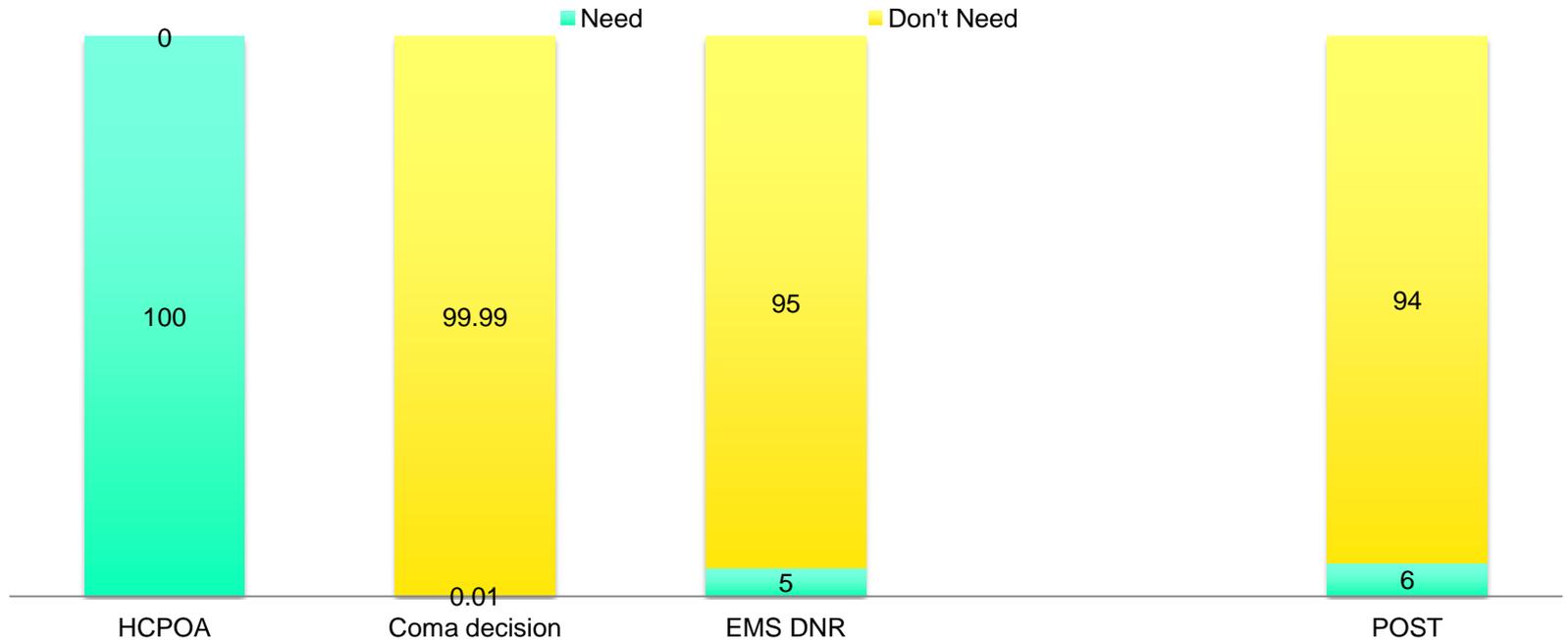


What is POLST?

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

How the POST fits in with existing advance directives

Estimate of Percent Need for Specific Advance Directives





EMSA #111 B
(Effective 4/1/2011)

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.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

A
Check One

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
Check One

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: _____

CCheck
One**ARTIFICIALLY ADMINISTERED NUTRITION:***Offer food by mouth if feasible and desired.*

- No artificial means of nutrition, including feeding tubes. Additional Orders: _____
- Trial period of artificial nutrition, including feeding tubes. _____
- Long-term artificial nutrition, including feeding tubes. _____

D**INFORMATION AND SIGNATURES:**Discussed with: Patient (Patient Has Capacity) Legally Recognized Decisionmaker

- Advance Directive dated _____ available and reviewed → Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____
- 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

Adapted with permission from California POLST Education Program
© January 2010 Coalition for Compassionate Care of California

Age 18

Complete an Advance Directive

Update Advance Directive Periodically

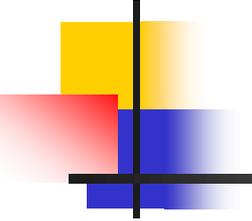
Diagnosed with Advanced Illness
or Frailty (*at any age*)

Complete a POLST Form

Change in health status

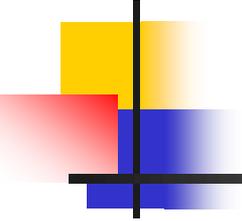
May Complete a new POLST Form

Treatment Wishes Honored



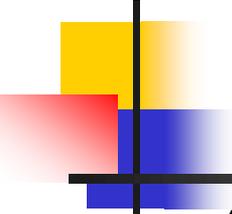
In North Carolina, POLST is MOST

- 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.



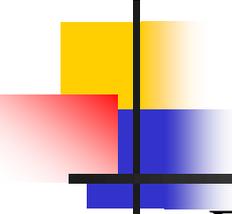
In North Carolina, POLST is MOST

- 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.



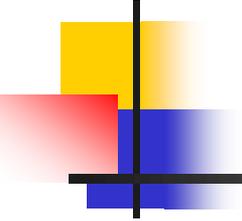
POST Pilot Project in 2012

- 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.

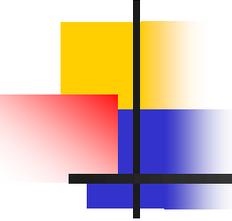


References

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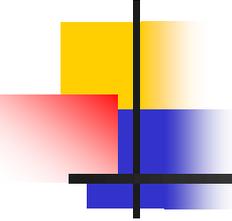
physician orders for life-sustaining treatment paradigm

www.POLST.org



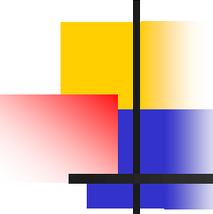
Communication Review of Systems (C-ROS)

- 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.



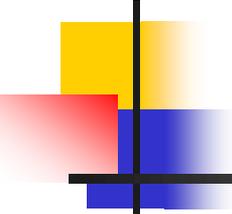
Communication Review of Systems (C-ROS)

- ◆ Ability to Consent
- ◆ Patient Voice
 - ◆ “Who would you like to have involved with your treatment?”
- ◆ Physician Voice
- ◆ Patient Understanding
- ◆ Physician Understanding
- ◆ Advance Directives
- ◆ Decisions



C-ROS Summary

- 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 “Who would you like to have involved with your treatment?” and
 - “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.

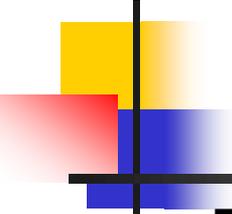


Why will the C-ROS help with Communication, Consent and Decision-Making in hospitals in SC?

- 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.

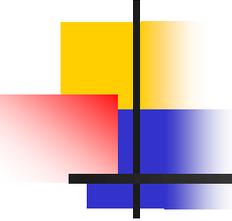


"There's no easy way I can tell you this, so I'm sending you to someone who can."



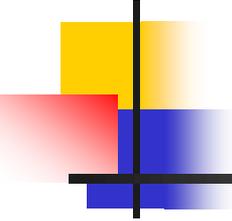
Palliative Care Defined

- 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 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 team of doctors, nurses, and other specialists who work with the patients other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage of a serious illness, and can be provided together with curative treatment.



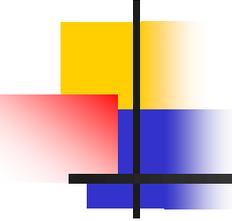
The Fiscal Imperative

- 25% of all Medicare spending goes to pay for care for 5% of patients in their final year of life
- Last year, Medicare paid \$55 billion just for doctor and hospital bills during the last two months of patients' lives
- Estimated that 20 to 30 percent of these medical expenses may have had no meaningful impact
- More than the budget for the Department of Homeland Security, or the Department of Education
- Hospital of the future will have to efficiently and effectively treat chronically and seriously ill in order to survive



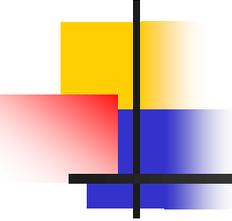
The Demographic Imperative

- Chronically ill, aging population is growing
- The 63% of Medicare patients with 2 or more chronic conditions account for 95% of Medicare spending (CDC)
- The number of people over age 85 will double to 9 million by the year 2030 (CDC)



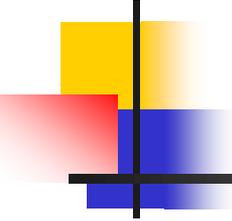
Value = Quality/Cost

- 100K deaths per year from medical error
- Millions harmed by overuse, misuse
- Fragmentation
- EBM < 50% of the time
- 50 million Americans without access
- US ranks 40th worldwide in quality



Denominator Problems (Cost)

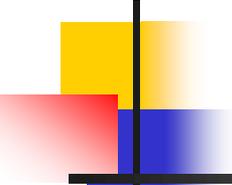
- Insurance premiums increased by 131% last 10 years
- US spends 18% GDP on health
- 50% of state spending
- Healthcare spending is the primary threat to the American economy and way of life



Paradigm Shift

- “The nature of our healthcare system, specifically the reliance on unregulated fee-for-service and specialty care, explains **both** the increased spending and deterioration in survival”.

Muening, PA; Glied, S; What Changes In Survival Rates Tell Us About US Health Care. Health Affairs Oct. 2010



Berwick's 6 Categories of Waste

- Failures of Care Delivery: Much of this is the costs of medical error
- **Failures of Care Coordination:** The costs when patients fall through the holes in our fragmented care system
- **Overtreatment:** The costs when patients are subjected to "care" that can not possibly help them (and likely hurts them)
- Administrative complexity: Costs from misguided policies and rules (such as complex billing procedures requiring doctors and hospitals to hire armies of coders)
- Pricing failures: Costs resulting from the absence of transparency and complex markets (i.e., why is the cost of a MRI in the US cost several times the cost in other countries?)
- Fraud and abuse: The costs of fake billing and health care scams
- getting serious about these 6 causes of waste at a minimum could save 21% of US health care costs (that's \$558 billion dollars--\$558,000,000,000)

Berwick, D. Eliminating Waste in US Healthcare JAMA. 2012;307(14):1513-1516

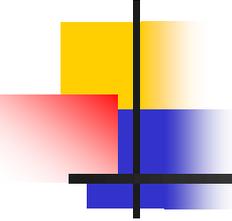
Definition of Quality in Healthcare

In healthcare, defined as care that is:

- Patient-centered
- Beneficial
- Timely
- Safe
- Equitable
- Efficient

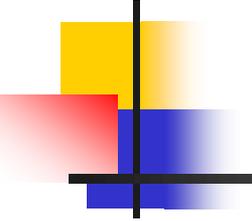
National Quality Forum www.qualityforum.org

Institute for Healthcare Improvement www.ihl.org



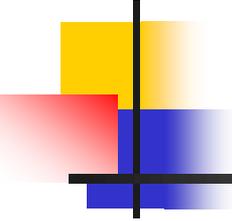
Palliative Care and ACO, PCMH

- Improve quality and control cost for high need patient populations by focusing on patient-centered, goal driven, intensive care coordination (C-ROS)
- Identify and treat problems before crises prompt preventable ED visits/hospitalization (POST)
- Shift provider incentives from FFS drivers of quantity to payment based on quality



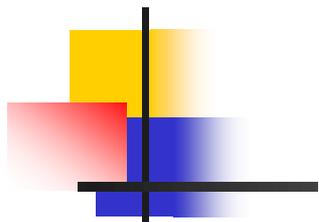
Palliative Care

- The only intervention that has been shown to directly enhance the value equation
- Patients transferred to more supportive, less costly settings
- Non-beneficial or harmful imaging, lab, specialty consultations, procedures avoided
- Patients discharged sooner and more safely



12 studies on palliative care impact

- All but one revealed significant cost savings
- The largest and highest quality study showed the average per patient net cost saved=\$2659
- At best palliative care teams have 1.5% penetration nationally=\$1.2 billion cost savings
- Ideal to expand capacity to see 6% = \$4



SOUTH CAROLINA

Grade: C

South Carolina

Select a County for a List of Palliative Care Programs

Charleston

STATE RANKINGS

Click on a hospital group to compare the state, regional and national values in a chart.

Hospitals with Palliative Care



Hospital Group	State	Region	National
For-profit	27% (4/15)	6% (1/18)	26% (108/419)
Public	30% (3/10)	38% (10/26)	54% (192/356)
Sole Community Provider	44% (4/9)	11% (1/9)	37% (151/406)
300 or more beds	92% (12/13)	50% (6/12)	85% (597/699)
50 or more beds	51% (22/43)	28% (16/58)	63% (1568/2489)
Less than 50 beds	21% (3/14)	4% (1/28)	22% (326/1500)

Table 2 Prevalence of Palliative Care Health Care Professionals *(continued)*

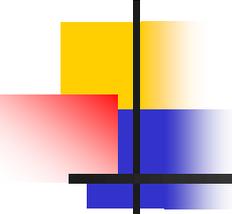
	ABHPM-Certified Physicians	Medicare Deaths per Certified Physician	Medicare Hospital Deaths per Certified Physician	NBCHPN-Certified Advanced Practice Nurses	Medicare Deaths per Certified APN	Medicare Hospital Deaths per Certified APN	NBCHPN-Certified Registered Nurses	Medicare Deaths per Certified RN	Medicare Hospital Deaths per Certified RN	Medicare Deaths (2005)	Medicare Deaths Occurring Within a Hospital (2005)
Georgia	53	768	216	10	4,068	1,147	297	137	39	40,681	11,474
Kentucky	30	874	270	8	3,277	1,012	213	123	38	26,212	8,094
Louisiana	33	756	225	3	8,317	2,479	87	287	85	24,950	7,436
Maryland	51	535	164	14	1,949	597	232	118	36	27,288	8,361
Mississippi	11	1,698	592	—	—	—	38	491	171	18,673	6,512
North Carolina	89	553	172	20	2,461	766	477	103	32	49,224	15,314
Oklahoma	33	699	202	—	—	—	120	192	56	23,082	6,671
South Carolina	32	783	269	5	5,013	1,723	181	138	48	25,067	8,613
Tennessee	44	808	258	12	2,964	946	151	236	75	35,570	11,352
Texas	221	438	117	21	4,612	1,232	622	156	42	96,855	25,863
Virginia	76	511	162	23	1,689	536	281	138	44	38,845	12,317
West Virginia	15	898	290	1	13,463	4,352	110	122	40	13,463	4,352
SOUTH	934	618	182	144	4,006	4,006	4,053	142	42	576,807	169,980



SOUTH CAROLINA

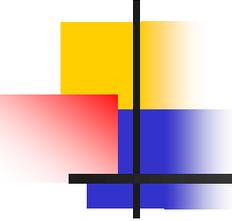
State Grade: **C**

State Congressional Districts	# of Hospitals with Palliative Care	Total # of Hospitals	% of Prevalence
SOUTH CAROLINA	22	43	51%
District 1	7	11	64%
District 2	2	4	50%
District 3	2	6	33%
District 4	4	6	67%
District 5	1	7	14%
District 6	6	9	67%



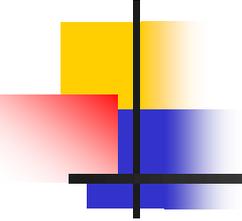
Recommendations to SC Hospitals

- Implement a palliative care program in your hospital that meets the quality standards published by the National Quality Forum (NQF)
- Provide comprehensive information about palliative care to your patients
- Educate your clinical staff in the principles and practices of palliative medicine (including POST) through continuing medical and nursing education programs



Recommendations to Academia

- Include education in pain and symptom management, communication training (e.g., “breaking bad news,” C-ROS, establishing goals of care, deciding on treatments) and working on an interdisciplinary team in the first and second years of medical school.
- Include mandatory clinical rotations in palliative medicine in the third and fourth years of undergraduate training for all medical students
- Increase the number of postgraduate fellowship training programs in palliative care



Conclusion

“The secret of the care of the patient is in caring for the patient.”

- Francis Peabody, 1925