

Readmission and End of Life: Everything's Better With Palliative Care

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About us.



- ✔ Founded in 1998
- ✔ Collaborative approach
- ✔ Committed to improving serious illness care

Objectives

- Differentiate palliative care from hospice
- Compare Advance Health Care Directive and POLST as tools for advance care planning
- Place ACP conversations in continuum of care
- Implement effective approaches to advance care planning and POLST

Why Advance Care Planning and Palliative Care?

- Proven to reduce readmissions and hospitalizations

Kernick et al. 2018 Systematic Review

- ACP ↓ hospitalizations
- ACP ↑ use of PC
- Supported deaths in desired location

Auerbach et al. 2015 Preventable Readmissions

- Inadequate sx mgmt
- Poor care coordination & monitoring of pt
- Pt need for addl svcs
- Lack of ACP/GOC

Searle et al. 2022 Systematic Review of RCTs

- ACP & PC intervention “significant” ↓ hospitalizations from NHs

O’Connor et al. 2015 PC to Prevent Hospital Readmissions

- PC consults in hospital reduced readmissions by 50%
- When ACP/GOC included, reduced by 75%

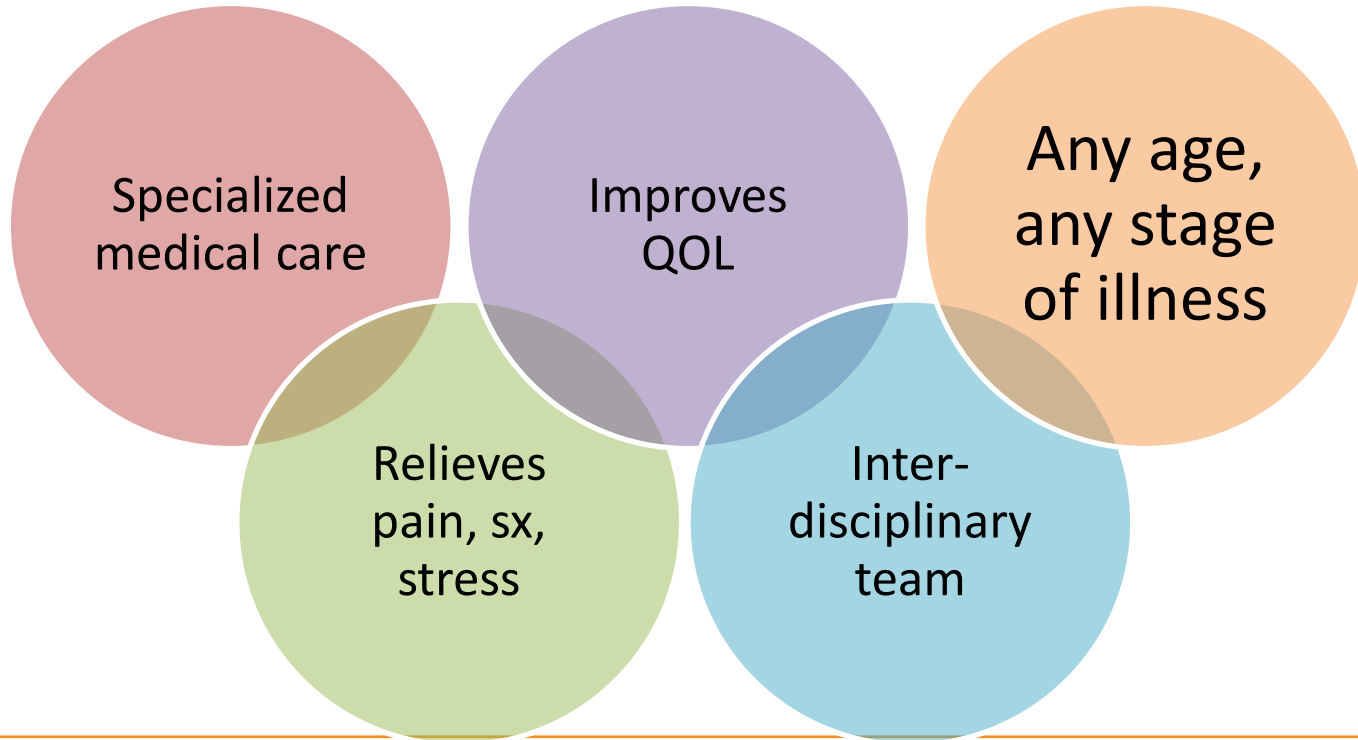
Baxter et al. 2018 PC Across the Continuum

- PC in NH ↓ readmissions from NF from 26% to 10%

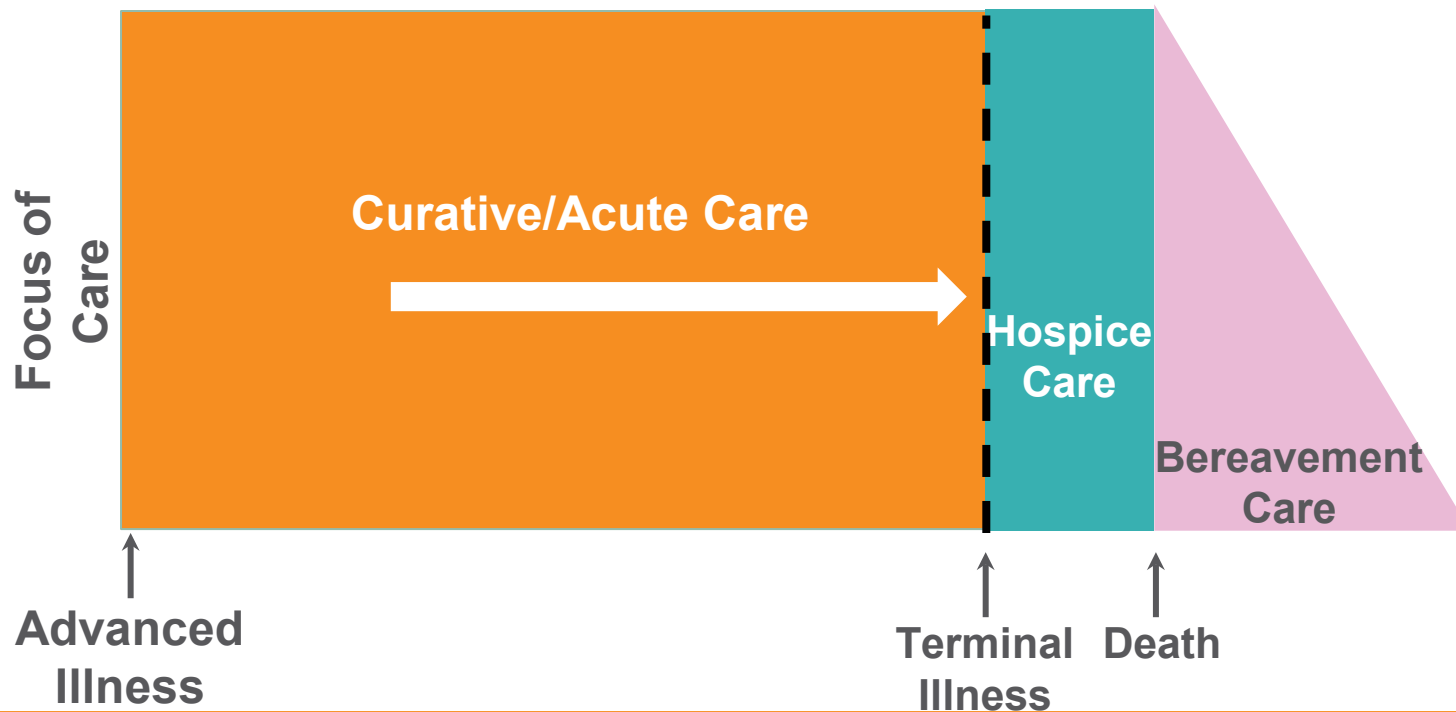


Palliative Care

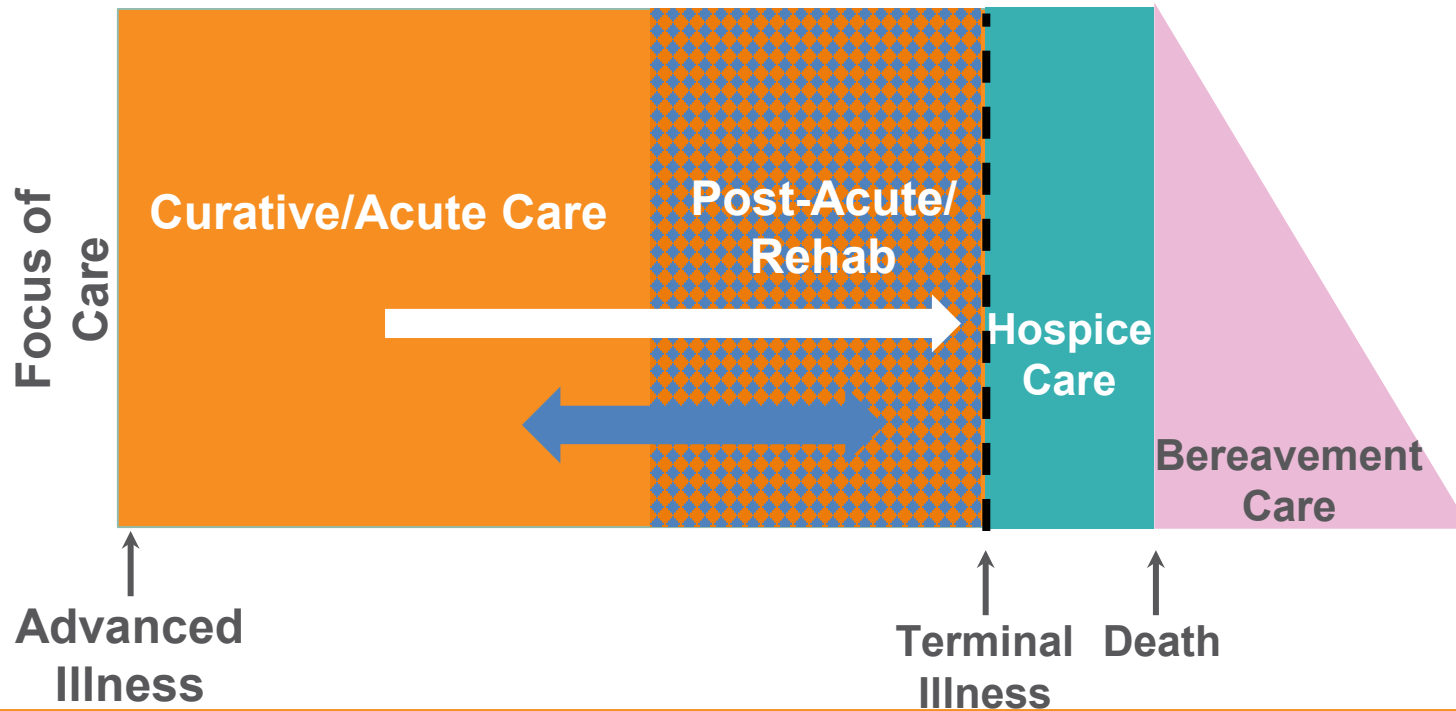
What Is Palliative Care?



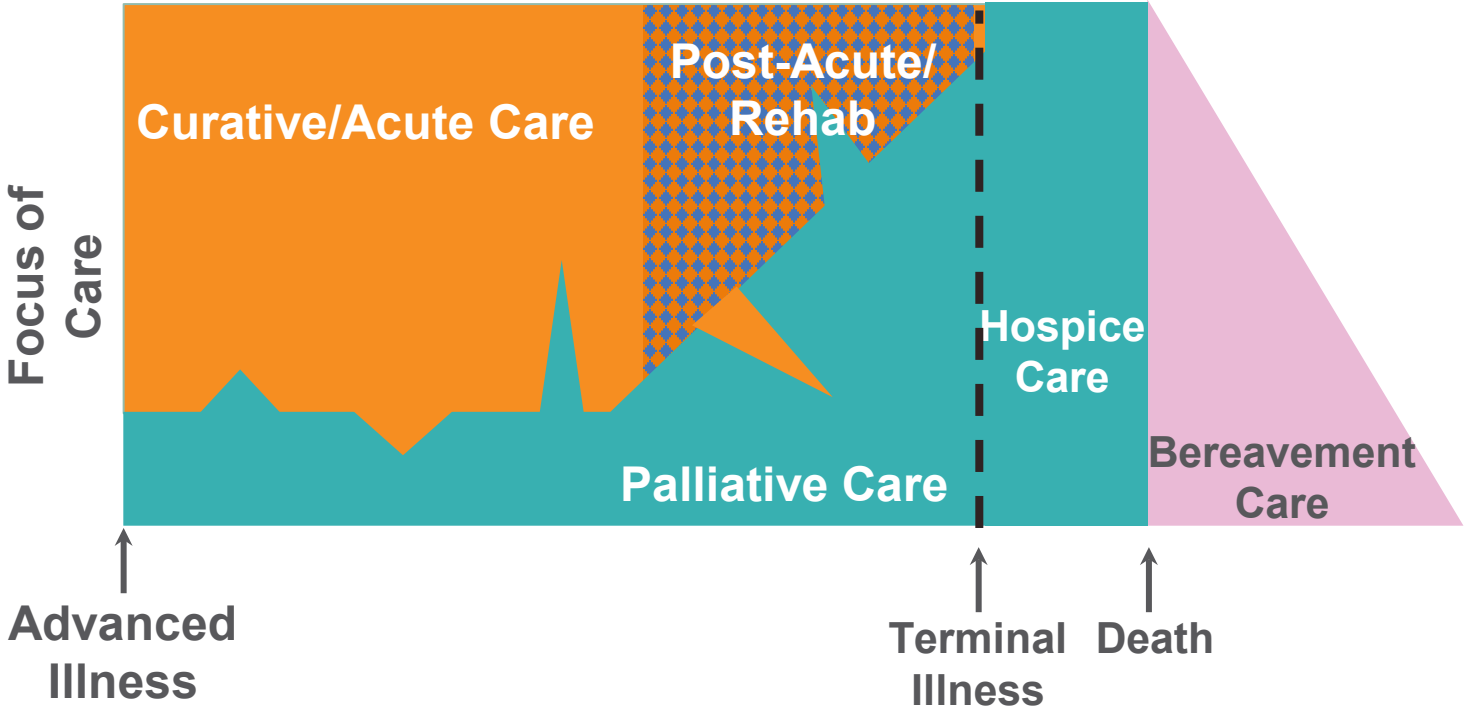
Traditional Medical Model



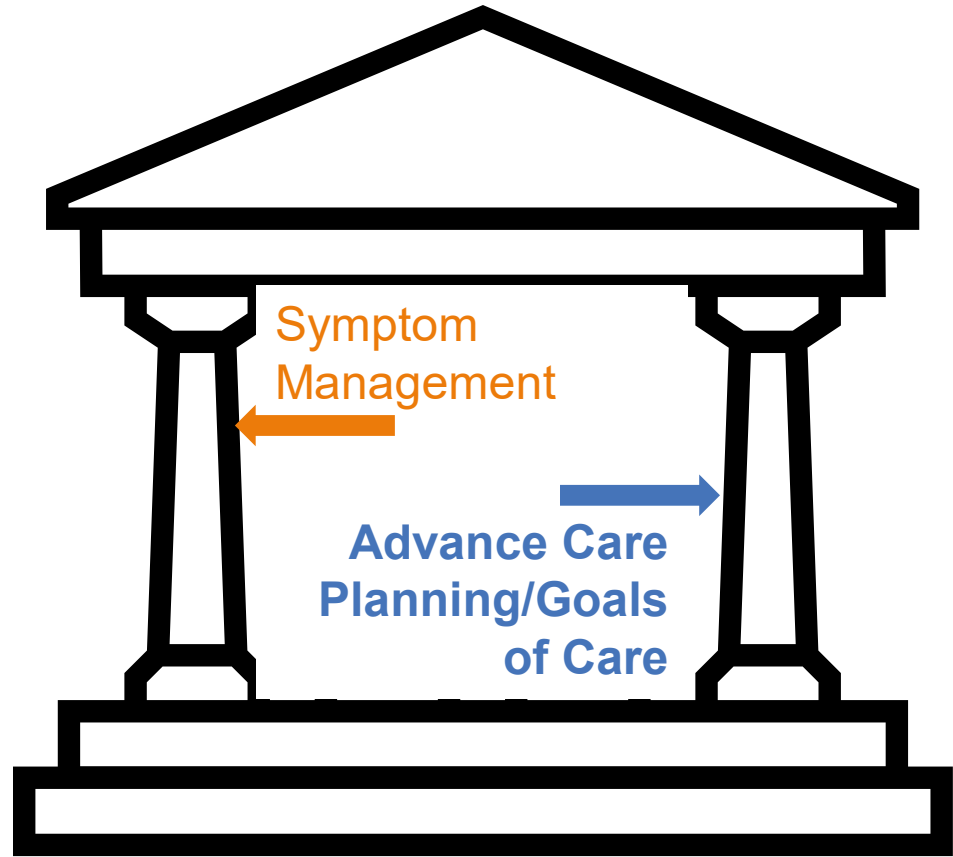
Linear Medical Model



Integrated Care Model



Twin Pillars of Palliative Care



Palliative Care v. Hospice

Palliative Care

Serious illness

Any age, any stage

Along with curative tx

Programs/svcs vary

Payment models vary

Hospice

Terminal illness

≤ 6 months prognosis

No curative tx

Regulated, standardized

Set per-diem rates

Palliative Care v. Hospice

Pallia

Team-based care focused
on relieving pain,
improving QOL, supporting
patient and caregiver
preferences and needs

prognosis

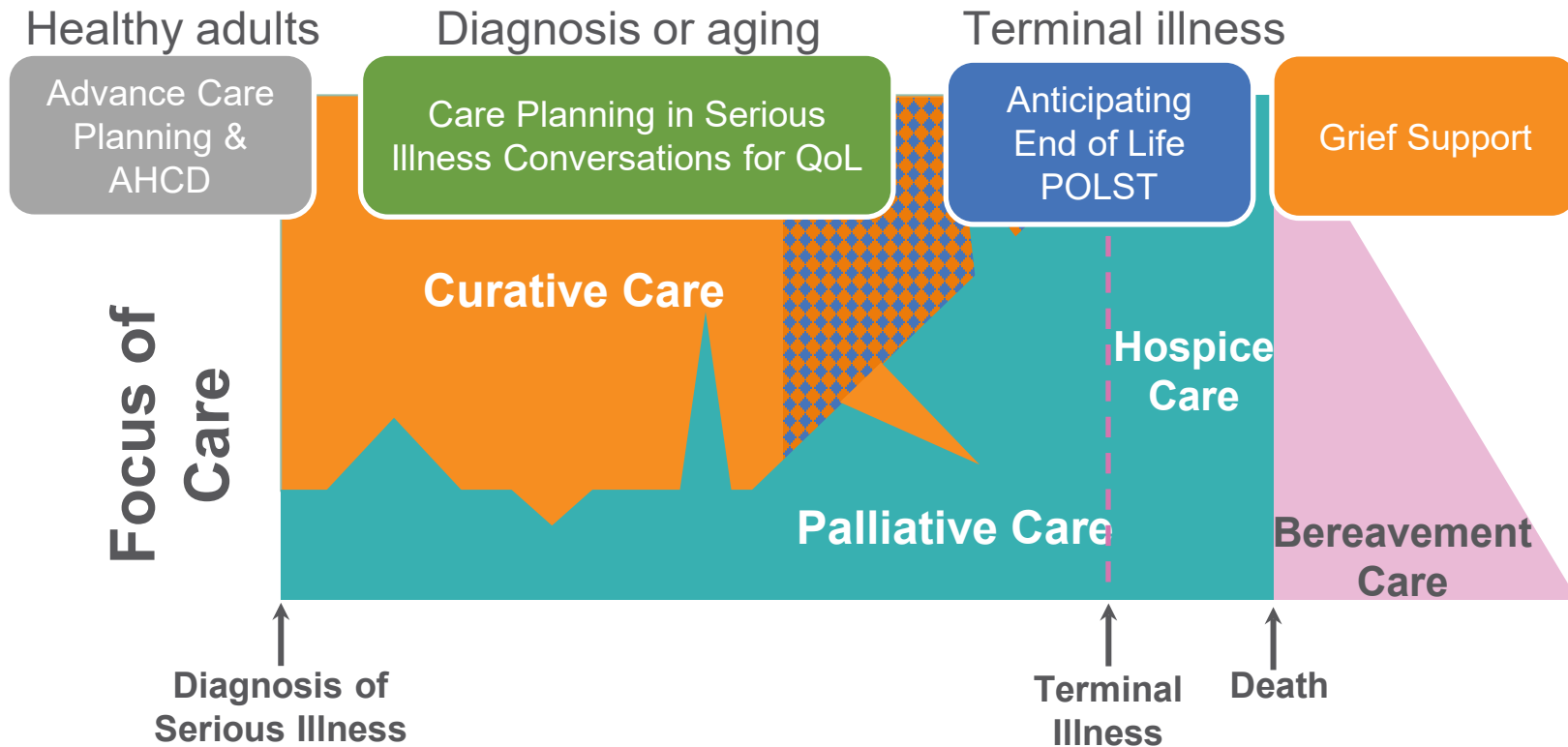
regulated, standardized

Set per-diem rates



Care Planning

Focus for Care Planning



Advance Care Planning

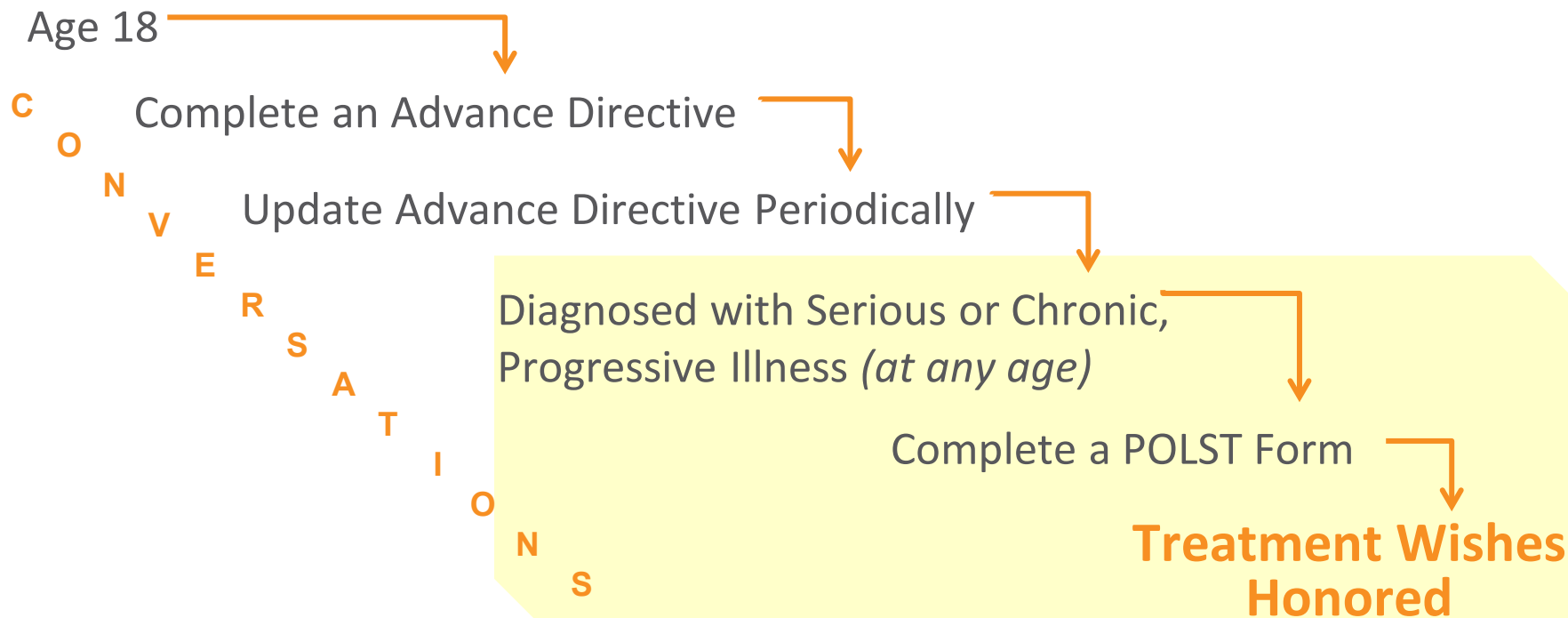
ACP is a process that supports a person

- At any age or stage of health
- In understanding & sharing personal values, life goals, and preferences
- Regarding future medical care

The goal of ACP is to

- Identify a trusted surrogate decision maker
- Help ensure that people receive medical care consistent with their values, goals and preferences during serious or chronic illness

ACP Across the Continuum



ACP Process

A series of conversations about

The realities facing the individual

- *Diagnoses, abilities, limitations, resources, treatment preferences*

What is important to the individual

- *Hopes, goals, and concerns about the future*

Completing documents

- *AHCD, POLST*

Honoring wishes



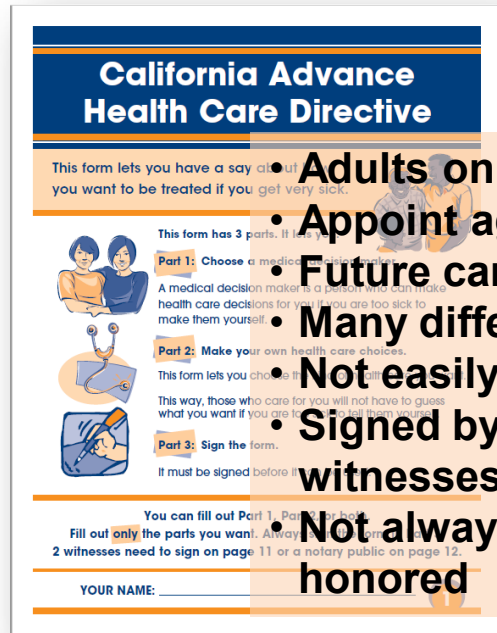
POLST

POLST: Physician Orders for Life-Sustaining Treatment

- Physician's/APP's Medical Order
- Provides instructions regarding specific medical treatment NOW
- Must be accepted/honored across healthcare settings
- Valid if appropriately signed
- ALWAYS VOLUNTARY

The image shows a sample of a POLST form. The title is "Physician Orders for Life-Sustaining Treatment (POLST)". The form is divided into sections A, B, C, and D, each with checkboxes for various medical interventions and preferences. Section A covers CPR, Section B covers medical interventions like intubation and feeding, Section C covers artificial nutrition and hydration, and Section D covers other medical orders. The form is signed by a physician and includes fields for patient name, address, and phone number.

Advance Health Care Directive vs POLST



California Advance Health Care Directive

This form lets you have a say about the health care you want to be treated if you get very sick.

This form has 3 parts. If you are not ready to make a medical decision, you can fill out Part 1. If you are ready to make a medical decision, you can fill out Part 2. If you are ready to sign the form, you can fill out Part 3.

Part 1: Choose a medical decision maker.
A medical decision maker is a person who can make health care decisions for you if you are too sick to make them yourself.

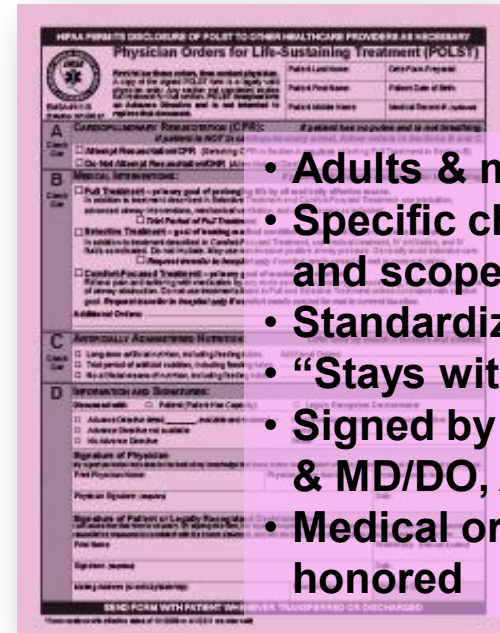
Part 2: Make your own health care choices.
This form lets you choose the health care you want. This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Part 3: Sign the form.
It must be signed before it can be used.

You can fill out Part 1, Part 2, or both. Fill out **only** the parts you want. Always have **at least 2 witnesses need to sign on page 11 or a notary public on page 12.**

YOUR NAME: _____

- Adults only
- Appoint agent
- Future care instructions
- Many different forms
- Not easily accessible
- Signed by person, witnesses or notary
- Not always actionable or honored



Physician Orders for Life-Sustaining Treatment (POLST)

Physician's Use Only: This order is a medical order. It is not a form for patients to fill out. It is a form for healthcare providers to fill out. It is a form for healthcare providers to fill out. It is a form for healthcare providers to fill out.

A. CARDIORESPIRATORY RESUSCITATION (CPR):
 Advanced Full Resuscitation (CPR) - including chest compressions, rescue breathing, and use of a resuscitator.
 Do Not Attempt Resuscitation (DNR) - including chest compressions, rescue breathing, and use of a resuscitator.

B. MEDICAL INTERVENTIONS:
 Full Treatment - primary goal of prolonging life by all available medical means in addition to treatment described in Resuscitation.
 Limited Treatment - goal of easing as much suffering as possible while avoiding aggressive life-prolonging treatments.
 Comfort-Focused Treatment - primary goal of relieving pain and suffering with medication by any means available, including the use of sedation. Do not use life-sustaining treatments.

C. ANTIANTHROPIC INTERVENTIONS:
 Long-term artificial nutrition, including feeding tubes.
 Total parenteral nutrition, including feeding tubes.
 No artificial means of nutrition, including feeding tubes.

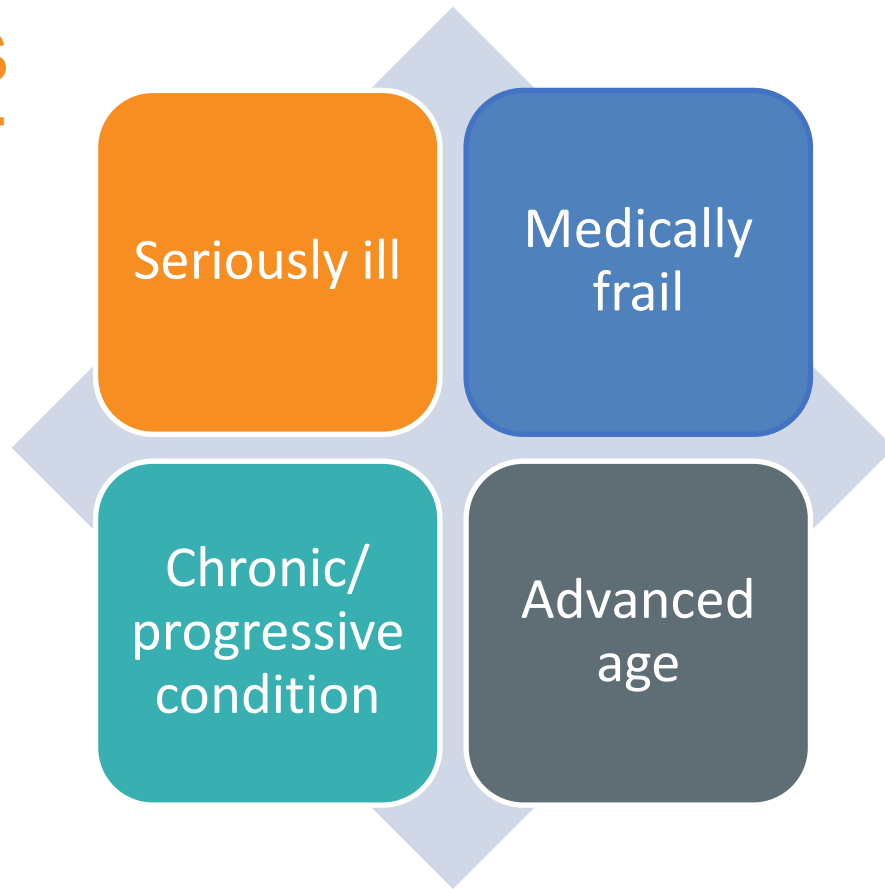
D. DEhydration AND DIsorders:
 Advance Care Directive
 Advance Directive not available
 No Advance Directive

Signature of Physician
 Signature of Patient or Legally Responsible Person
 Signature of Witness

SEND FORM WITH PATIENT, MEDICINE, TREATMENT RECORD OR DISCHARGE

- Adults & minors
- Specific choices for tx and scope
- Standardized form
- “Stays with patient”
- Signed by patient/agent & MD/DO, APP
- Medical order; must be honored

Indications for POLST





EMSA #111 B
(Effective 4/1/2017)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact **Physician/NP/PA**. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

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 patient has no pulse and is not breathing. If patient is 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 patient is found with a pulse and/or is breathing.*

Full Treatment – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

Trial Period of Full Treatment.

Selective Treatment – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

Request transfer to hospital only if comfort needs cannot be met in current location.

Comfort-Focused Treatment – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. *Request transfer to hospital only if comfort needs cannot be met in current location.*

Additional Orders: _____

C
Check One

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

Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

Trial period of artificial nutrition, including feeding tubes. _____

No artificial means of 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: _____
 Advance Directive not available Phone: _____
 No Advance Directive

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: (required)	Date:	

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. 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:
Mailing Address (street/city/state/zip):	Phone Number:

Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

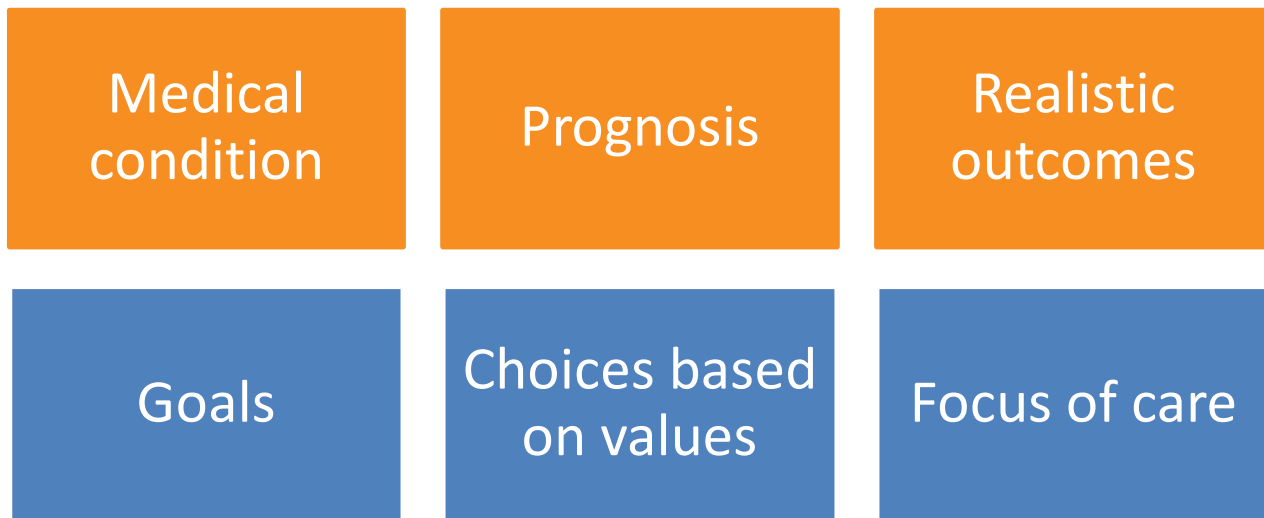
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY		
Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
NP/PA's Supervising Physician		Preparer Name (if other than signing Physician/NP/PA)
Name:	Name/Title:	Phone #:
Additional Contact <input type="checkbox"/> None		
Name:	Relationship to Patient:	Phone #:
Directions for Health Care Provider		
Completing POLST		
<ul style="list-style-type: none"> • Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences. • POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts. • POLST must be completed by a health care provider based on patient preferences and medical indications. • A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known. • A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately. • To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy. • If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form. • Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible. 		
Using POLST		
<ul style="list-style-type: none"> • Any incomplete section of POLST implies full treatment for that section. 		
<i>Section A:</i>		
<ul style="list-style-type: none"> • If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation." 		
<i>Section B:</i>		
<ul style="list-style-type: none"> • When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). • Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations. • IV antibiotics and hydration generally are not "Comfort-Focused Treatment." • Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment." • Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel. 		
Reviewing POLST		
It is recommended that POLST be reviewed periodically. Review is recommended when:		
<ul style="list-style-type: none"> • The patient is transferred from one care setting or care level to another, or • There is a substantial change in the patient's health status, or • The patient's treatment preferences change. 		
Modifying and Voiding POLST		
<ul style="list-style-type: none"> • A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line. • A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient'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 PATIENT WHENEVER TRANSFERRED OR DISCHARGED		

POLST ...

- *Is always voluntary* for patients
- Is not indicated for all patients
- Should be revisited when an unexpected or significant change of condition occurs
- Can be voided or changed by patient at any time
- Surrogate can void or change in discussion with provider *when circumstances change*

POLST Is Not Just a Check Box

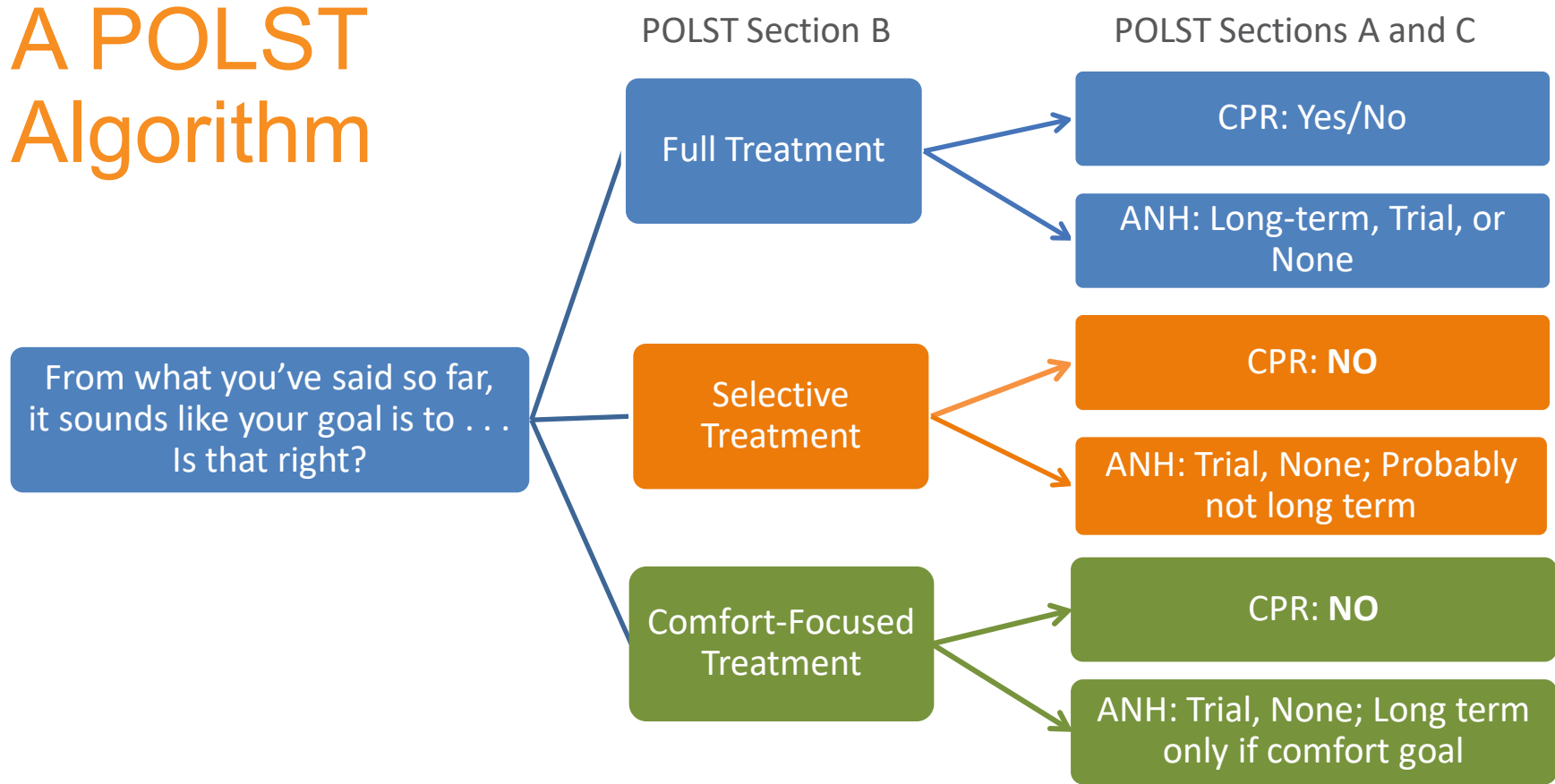
It represents a conversation



Conversation Starters

- Let's talk specifically about a few important medical choices we might need to make in a hurry.
- This is a POLST form. We use it to record those choices so anyone caring for you will know what you want. Once it's done and signed, it's a medical order – like a prescription. You keep it with you, even when you go home. Any doctor or emergency responder has to follow the orders as we've marked them.
- We don't have to use this form, but we've found that it's really helpful so everyone can be on the same page. Sound good?

A POLST Algorithm



Decision Aids

Patient-friendly explanations of key medical procedures to aid treatment decisions

Available in English, Spanish, Chinese, & Vietnamese



CPR Decision Aid



What is CPR?

CPR (Cardio-Pulmonary Resuscitation) is an attempt to restart a person's heart when the heart has stopped beating or cannot pump blood.

How is CPR done?

Many people have seen CPR on television. TV often makes CPR look quick and easy. But it is not.

During CPR:

- The chest is pushed down two (2) or more inches many times each minute to make the heart pump.
- Strong electrical shocks may be given through the chest to make the heart beat at a normal rate.
- Medicine may be given, usually through an IV (intravenous) line.
- A mask may be placed on the face or a tube in the windpipe (trachea). These are often used to assist with breathing.



When do people need CPR?

It is needed when someone's heart stops. When this happens, healthcare providers will try CPR *unless* the person has completed a DNR (Do-Not-Resuscitate) order or a POLST (Physician Order for Life-Sustaining Treatment) that says they do not want CPR.

How might CPR help a person whose heart has stopped?

- The goal of CPR is to restart a person's heart.
- CPR can pump blood and support the body's organs, like the brain.
- CPR may give the medical team time to keep the heart beating after restarting.
- CPR may give the medical team time to try to find and to treat the medical problem that caused the heart to stop pumping.

Who should use this guide?

This decision aid is for people with serious illness.

It can be used to support medical decision-making and conversations about CPR.

Ventilator Decision Aid



What is a ventilator?

A ventilator (also called a breathing machine) does the work for the lungs when someone is unable to breathe on their own.

What happens when someone is attached to a ventilator? How is it done?

- A tube is placed through the mouth or nose down into the person's windpipe (trachea).
- A machine (the ventilator) pushes air through a tube into the lungs.
- Medicines are often given in an IV (intravenous) line to make a person sleepy so they feel less pain or discomfort.

When do people need a ventilator?

It may be needed for people who cannot breathe normally on their own. Breathing problems may be short-term (temporary) or long-term (permanent).

It is standard medical practice to use a ventilator to treat people who cannot breathe on their own, *unless* the person has chosen not to have it.

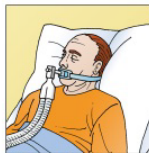
Reasons for short-term ventilator use may include:

- Surgery with anesthesia (medicine that makes you sleep).
- A sudden, serious illness, or a severe injury.
- Problems caused by serious lung disease, such as COPD (chronic obstructive pulmonary disease), emphysema, asthma, or pneumonia.
- Fluid in the lungs from heart problems or swelling.

Reasons for long-term ventilator use may include:

- Extreme weakness, when the breathing muscles do not work well.
- Being in a coma, when the brain and nerves that control breathing do not work normally.
- Diseases of the muscles or nerves, injury to the spinal cord, or severe lung damage.

Some people might permanently lose the ability to breathe on their own.



Who should use this guide?

This decision aid is for people with serious illness. It can be used to support medical decision-making and conversations about **treatment with a ventilator.**

Note: This document does not discuss options for non-invasive breathing support. That means ways to help you breathe without using a ventilator.

Tube Feeding Decision Aid



What is tube feeding or artificial nutrition?

Tube feeding (also called artificial nutrition) is a medical treatment that provides liquid food (nutrition) to the body.

How is tube feeding given?

It is given as a liquid through one of the following kinds of tubes:

- An **NG tube** (nasogastric tube) inserted through the nose into the stomach.
- A **PEG tube** (percutaneous endoscopic gastrostomy tube) or **G-tube** (gastrostomy tube) which is placed by surgery through the skin into the stomach. This surgery is used if nutrition is needed for more than a few weeks.



When do people need tube feeding?

When a person cannot eat normally or enough by mouth, or they have problems swallowing. These problems may be short-term (temporary) or long-term (permanent).

Reasons for short-term tube feeding may include:

- A sudden, serious illness, surgery, or a severe injury.
- Brief loss of alertness or awareness.
- To cope with special treatments, like radiation.

Reasons for long-term tube feeding may include:

- Inability to eat enough food by mouth.
- Loss of ability to eat normally or to swallow safely due to illness, stroke, or injury.
- Brain injury with a loss of alertness or awareness.
- Loss of ability to use (digest) food normally (for example, from bowel disease or stomach surgeries).

Who should use this guide?

This decision aid is for people with serious illness. It can be used to support medical decision-making and conversations about **tube feeding (artificial nutrition).**

Summing up

- “Cure sometimes; relieve often; *comfort always*”
- Plan ahead so care can match patient goals and preferences
- Palliative care + ACP + POLST = improved QOL & satisfaction; lower utilization of ED, hospital

Everything's

better with

Palliative Care!

References

- Auerbach, A.D., Kripalani, S., Vasilevskis, E.E., Sehgal, N., Lindenauer, P.K., Metlay, J.P., et al. (2016). Preventability and causes of readmissions in a national cohort of general medicine patients. *JAMA Internal Medicine*, 176, 484–493. 10.1001/jamainternmed.2015.7863
- Baxter, K.E., Rochon, T., & Lally, K.M. (2018). Providing palliative care across the continuum to reduce readmissions from community settings. *Annals of Long Term Care* online: <https://www.hmpgloballearningnetwork.com/site/altc/articles/providing-palliative-care-across-continuum-reduce-readmissions-community-settings>
- Kernick, L.A., Hogg, K.J., Millerick, Y., Murtagh, F.E.M., Djahit, A., Johnson, M. (2018). Does advance care planning in addition to usual care reduce hospitalisation for patients with advanced heart failure: A systematic review and narrative synthesis. *Palliative Medicine*, 32(10), 1539–1551. 10.1177/0269216318801162
- O'Connor, N.R., Moyer, M.E., Behta, M., Casarett, D.J. (2015). The impact of inpatient palliative care consultations on 30-day hospital readmissions. *Journal of Palliative Medicine*, 18(11), 956–961. 10.1001/jamainternmed.2017.6299
- Stephens, C.E., Hunt, L.J., Bui, N., Halifax, E., Ritchie, C.S., Lee, S.J. (2018). Palliative care eligibility, symptom burden, and quality-of-life ratings in nursing home residents. *JAMA Internal Medicine*, 178(1), 141–142. 10.1001/jamainternmed.2017.6299



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