Utilizing Principles from Evidence-Based Care Coordination Programs

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March 28, 2018
Objectives

• Identify specific evidence-based strategies your nursing home can adopt to reduce readmissions.

• Discover how your nursing home can participate in the HSAG Reducing Readmissions Preparation Program.

• Describe the role of advance care planning in improving care transitions.

• Examine how POLST\(^1\) fits into the spectrum of planning ahead in the nursing facility setting.
Overview of Evidence-Based Care Transitions Interventions

• Project BOOST
  – Better Outcomes for Older Adults through Safe Transitions

• Project RED
  – Re-engineered Discharge

• CTI®
  – Coleman Care Transitions Intervention

• INTERACT
  – Interventions to Reduce Acute Care Transfers
Project BOOST Overview

• Evidence-based intervention developed and tested by the Society of Hospital Medicine

• BOOST tools helps to identify high-risk patients

• Implementation tools
  – Target: Risk Assessment Tool 8Ps
  – Risk Stratification Process
  – Universal Patient Discharge Checklist
  – General Assessment of Preparedness (GAP)
  – Patient PASS: A Transition Record

1. Patient Preparation to Address Situations (after discharge) Successfully (PASS)
Project BOOST

- Improves the transition process by improving care across the continuum through the following elements:
  - Team communication
  - Content of the discharge summary
  - Patient education through teach-back
  - Medication safety and polypharmacy
  - Symptom management
  - Discharge and follow-up care

https://www.hospitalmedicine.org/clinical-topics/care-transitions/
## Project BOOST 8Ps Screening Tool
### Identifying Your Patient’s Risk for Adverse Events After Discharge

<table>
<thead>
<tr>
<th>Identifying Your Patient’s Risk for Adverse Events After Discharge The 8Ps</th>
<th>Risk Specific Intervention (Check all that apply.)</th>
</tr>
</thead>
</table>
| **Problems with medications** ☐ (polypharmacy [i.e., >10 routine meds – or high-risk medication including: insulin, anticoagulants, oral hypoglycemic agents, dual antiplatelet therapy, digoxin, or narcotics]) | ☐ Medication specific education using Teach Back provided to patient and caregiver  
☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g., warfarin, digoxin, and insulin)  
☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver  
☐ Elimination of unnecessary medications  
☐ Simplification of medication scheduling to improve adherence  
☐ Follow-up phone call at 72 hours to assess adherence and complications |
| **Psychological** ☐ (depression screen positive or history of depression diagnosis) | ☐ Assessment of need for psychiatric care if not in place  
☐ Communication with primary care provider, highlighting this issue if new  
☐ Involvement/awareness of support network insured |
| **Principal diagnosis** ☐ (cancer, stroke, DM, COPD, heart failure) | ☐ Review of national discharge guidelines, where available  
☐ Disease specific education using Teach Back with patient/caregiver  
☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms  
☐ Discuss goals of care and chronic illness model discussed with patient/caregiver |
| **Physical limitations** ☐ (deconditioning, frailty, malnutrition, or other physical limitations that impair their ability to participate in their care) | ☐ Engage family/caregivers to ensure ability to assist with post-discharge care assistance  
☐ Assessment of home services to address limitations and care needs  
☐ Follow-up phone call at 72 hours to assess ability to adhere to the care plan with services and support in place |
| **Poor health literacy** ☐ (inability to do Teach Back) | ☐ Committed caregiver involved in planning/administration of all discharge planning and general and risk specific interventions  
☐ Post-hospital care plan education using Teach Back provided to patient and caregiver  
☐ Link to community resources for additional patient/caregiver support  
☐ Follow-up phone call at 72 hours to assess adherence and complications |
| **Patient support** ☐ (social isolation, absence of support to assist with care, as well as insufficient or absent connection with primary care) | ☐ Follow-up phone call at 72 hours to assess condition, adherence, and complications  
☐ Follow-up appointment with appropriate medical provider within 7 days after hospitalization  
☐ Involvement of home care providers of services with clear communications of discharge plan to those providers  
☐ Engage a transition coach |
| **Prior hospitalization** ☐ (non-elective; in last 6 months) | ☐ Review reasons for re-hospitalization in context of prior hospitalization  
☐ Follow-up phone call at 72 hours to assess condition, adherence, and complications  
☐ Follow-up appointment with medical provider within 7 days of hospital discharge  
☐ Engage a transition coach |
| **Palliative care** ☐ (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness? “No” to 1st or “Yes” to 2nd = positive screen) | ☐ Assess need for palliative care services  
☐ Identify goals of care and therapeutic options  
☐ Communicate prognosis with patient/family/caregiver  
☐ Assess and address concerning symptoms  
☐ Identify services or benefits available to patients based on advanced disease status  
☐ Discuss with patient/caregiver role of palliative care services and the benefits and services available to the patient |

Society of Hospital Medicine. [https://www.hospitalmedicine.org/clinical-topics/care-transitions/](https://www.hospitalmedicine.org/clinical-topics/care-transitions/)
Project RED Overview

• Evidence-based intervention developed and tested by Boston University Medical School.
• Focus is patient-centered care with an emphasis on educating the patient about their comprehensive discharge plan.
• Project RED can be used for any discharge transfer to a home, nursing home, or home health agency.
• Project RED is a cost effective evidence-based intervention.

11 Components of Project RED

1. Make appointments for follow-up appointments and post-discharge tests
2. Plan for follow up of results from labs or studies
3. Organize post-discharge outpatient services/equipment
4. Identify correct meds and obtainment of meds
5. Reconcile discharge plan with national guidelines
6. Teach written discharge plan to patient
7. Educate patient about diagnosis
8. Assess degree of patient understanding
9. Review with patient what to do if there are problems
10. Expedite transmission of discharge summary to clinicians
11. Provide telephone reinforcement of discharge plan

# After Hospital Care Plan Sample

<table>
<thead>
<tr>
<th>What time of day do I take this medicine?</th>
<th>Why am I taking this medicine?</th>
<th>Medicine name and Amount</th>
<th>How many (or how much) do I take?</th>
<th>How do I take this medicine?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td>Blood pressure</td>
<td>PROCARDIA XL NIFEDIPINE 90 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td>Morning</td>
<td>Blood pressure</td>
<td>HYDROCHLOROTHIAZIDE 25 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td>Morning</td>
<td>Blood pressure</td>
<td>CLONIDINE HCl 0.1 mg</td>
<td>3 pills</td>
<td>By mouth</td>
</tr>
<tr>
<td>Morning</td>
<td>Cholesterol</td>
<td>LIPITOR ATORVASTATIN CALCIUM 20 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td>Morning</td>
<td>Stomach</td>
<td>PROTONIX PANTOPRAZOLE SODIUM 40 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td>Morning</td>
<td>Heart</td>
<td>ASPIRIN EC 325 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td>Morning</td>
<td>To stop smoking</td>
<td>NICOTINE 14 mg/24 hour</td>
<td>1 patch</td>
<td>On skin</td>
</tr>
<tr>
<td>Then, after 4 weeks use →</td>
<td></td>
<td>NICOTINE 7 mg/24 hour</td>
<td>1 patch</td>
<td>On skin</td>
</tr>
</tbody>
</table>
CTI Overview

• Evidence-based program founded by Eric A. Coleman, MD, MPH.

• Four-week program that encourages patients to take a more active role in their healthcare and ensures their needs are met during the transition from hospital to home.

• Facilitated by a care transitions coach in which patients with complex care needs receive tools to learn self-management skills to ensure needs are met during transition from hospital to home.

http://www.caretransitions.org/
## Components of CTI Pillars

<table>
<thead>
<tr>
<th>Pillar</th>
<th>Medication Self-Management</th>
<th>Dynamic Patient-Centered Record</th>
<th>Follow-Up</th>
<th>Red Flags</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td>Patient is knowledgeable about medications and has system</td>
<td>Patient understands and manages a personal health record (PHR)</td>
<td>Patient schedules and completes follow-up visit with primary care provider/specialist</td>
<td>Patient is knowledgeable about indications that condition is worsening and how to respond</td>
</tr>
<tr>
<td><strong>Hospital Visit</strong></td>
<td>Discuss importance of knowing medications</td>
<td>Explain PHR</td>
<td>Recommend primary care provider follow-up visit</td>
<td>Discuss symptoms and drug reactions</td>
</tr>
<tr>
<td><strong>Home Visit</strong></td>
<td>Reconcile pre- and post-hospitalization medication lists</td>
<td>Review and update PHR</td>
<td>Emphasize importance of the follow-up visit</td>
<td>Discuss symptoms and side effects of medications</td>
</tr>
<tr>
<td></td>
<td>Identify and correct any discrepancies</td>
<td>Review discharge summary</td>
<td>Practice and role-play questions for the primary care provider</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Encourage patient to share PHR with primary care provider and/or specialist</td>
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</tr>
<tr>
<td><strong>Follow-Up Calls</strong></td>
<td>Answer any remaining medication questions</td>
<td>Discuss outcome of visit with primary care provider or specialist</td>
<td>Provide advocacy in getting appointment, if necessary</td>
<td>Reinforce when/if primary care provider should be called</td>
</tr>
</tbody>
</table>
INTERACT Overview

- Quality improvement program that focuses on the management of acute change in resident condition.
- Includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.
  - Quality improvement tools
  - Communication tools
  - Decision support tools: change-in-condition file cards and care paths
  - Advance care planning tools

http://www.pathway-interact.com/
Using the INTERACT Tools
In Every Day Care

- Advance Care Planning Tools
- Care Paths
- Acute Change in Condition File Cards
- Hospital Communication Tools
- Hospitalization Rate Tracking Tool
- Quality Improvement Tool for Review of Acute Care Transfers
- New Resident Admission Resident Re-Assessment
- Change in Resident Status Noted
- CNA, Other Direct Care Staff, or Family Alerts LPN/RN
- LPN/RN Evaluation
- MD/NP/PA Notified
- Acute Care Transfer
- Quality Improvement Program
- Apply learning to improve care processes and education
- Medication Reconciliation Worksheet
- Stop and Watch Early Warning Tool
- SBAR Form and Progress Note
- Transfer Checklist Envelope
- Transfer Data List and Sample Forms
Adopting Evidence-Based Programs in the Nursing Home Setting

• Many of the programs also apply to the nursing home setting
  – Components of CTI, BOOST, RED

• INTERACT: created specifically for nursing homes

• HSAG Nursing Home Readmission Assessment
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</thead>
<tbody>
<tr>
<td><strong>Project Re-Engineered Discharge (RED)</strong></td>
<td>Standardized discharge intervention in which a designated Discharge Advocate (DA) facilitates the care transition process by: • Coordinating the medical team. • Providing patient education (disease and medication). • Improving care quality. • Arranging after-hospital care plan with patients and family. <a href="http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html">www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html</a></td>
<td>• Project RED Discharge Advocate Training Manual • Patient education • Post-discharge clinic follow-up (testing, services, plan, etc.) • Medication plan • Emergency preparedness • Teach-back • Written discharge to patient • Telephone follow-up</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Better Outcomes for Older adults through Safe Transitions (BOOST)</strong></td>
<td>Comprehensive guide developed by the Society of Hospital Medicine that provides resources to optimize the hospital discharge process and mitigate and prevent known complications and errors that occur during the transitions. <a href="http://www.hospitalmedicine.org/clinical-topics/care-transitions/">www.hospitalmedicine.org/clinical-topics/care-transitions/</a></td>
<td>• BOOST Implementation Guide to Improve Care Transitions • Screening/assessment tools • Discharge checklist/instructions • Transition record • Teach-back • Risk-specific interventions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Care Transitions Intervention® (CTI) (Coleman Model)</td>
<td>Four week program facilitated by a care transitions coach in which patients with complex care needs receive tools and learn self-management skills to ensure needs are met during transition from hospital to home; focuses on four conceptual areas (or “pillars”): 1. Medication self-management 2. Dynamic, patient-centered recordkeeping 3. Follow-up 4. Red flags <a href="http://www.caretransitions.org">www.caretransitions.org</a></td>
<td>Personal health record</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge preparation checklist</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication discrepancy tool</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td></td>
<td></td>
<td>Patient Activation Assessment tool</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Interventions to Reduce Acute Care Transfers (INTERACT)</td>
<td>Quality improvement program designed to improve the identification, evaluation, and communications about changes in resident status. <a href="http://www.pathway-interact.com">www.pathway-interact.com</a></td>
<td>INTERACT Tools</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SBAR Communication Tool</td>
<td></td>
<td></td>
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<td></td>
<td>✓</td>
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<tr>
<td></td>
<td></td>
<td>Quality Improvement Tool</td>
<td></td>
<td></td>
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<td></td>
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<td>✓</td>
</tr>
</tbody>
</table>

[www.caretransitions.org](http://www.caretransitions.org) | [www.pathway-interact.com](http://www.pathway-interact.com) |
Work with your Reducing Readmissions Committee to complete the readmission assessment

- Focused on operational processes
- Pre-admission
- Admission/transfer from hospital

<table>
<thead>
<tr>
<th>Assessment Items</th>
<th>Yes, In Place With Consistent Use</th>
<th>Yes, In Place With Partial Use</th>
<th>Under Development</th>
<th>No, Not Doing at All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational Processes</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1. Do you track and trend transfers using a readmission dashboard?</td>
<td></td>
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</tr>
<tr>
<td>Rationale: “A dashboard is an ideal way to prioritize the most important indicators for a nursing home and encourage regular monitoring of the results. Nursing homes should include readmission as one of the measures in your dashboard.”</td>
<td></td>
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</tr>
</tbody>
</table>

Submit completed form online or scan and email to your state contact:

Sign up Today—Start the Journey

Complete commitment agreement:

Nursing Home Reducing Readmissions Preparation Program

Readmissions Penalties Are Coming. Are You Ready?
Did you know that Medicare is changing the reimbursement structure for nursing homes starting October 2018? A new factor that will contribute to your nursing home reimbursement includes hospital readmissions. Participating in this program will help improve knowledge on new readmission quality measures, identify strategies to prevent readmissions, and help facilities be a preferred provider to your local hospitals.

Program Activities
- Establish a Reducing Readmissions Committee to create a successful program in your facility.
- Track and trend Medicare Fee-for-Service 30-day readmissions data.
- Participate in monthly Intervention Strategies and Clinical Skills Webinar Series to reduce readmissions.
- Use Quality Assurance and Performance Improvement (QAPI) techniques to implement readmission interventions.
- To help keep you on track, participate in monthly coaching calls with HSAG to share best practices for implementing interventions, and share successes and challenges.

California nursing homes: sign up here today!
What’s involved? Steps in the Preparation Journey

Materials to Get You Started
- Program Overview: What is the Reducing Readmissions Preparation Program? Download the Program Overview.
- Commitment Agreement: Ready to join? Sign up online or download the Agreement PDF and fax it back.
- Program Criteria: What’s involved? See our Program Criteria page for details, or download the Program Criteria flyer.
- Webinar Calendar: Webinars will help you along the way. To see upcoming events, download the Webinar Series Calendar.

California
www.hsag.com/ca-rrpp

Arizona
www.hsag.com/az-rrpp

Ohio
www.hsag.com/oh-rrpp
Links to tools are available at:

- [https://www.hsag.com/medicare-providers/care-coordination/](https://www.hsag.com/medicare-providers/care-coordination/)

**Better Outcomes for Older adults through Safe Transitions (BOOST)**


**Project Re-Engineered Discharge (RED)**

- [http://www.bu.edu/fammed/projectred/](http://www.bu.edu/fammed/projectred/)

**Care Transitions Intervention® (CTI) (Coleman Model)**

- [http://www.caretransitions.org/](http://www.caretransitions.org/)

**Interventions to Reduce Acute Care Transfers (INTERACT)**


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*Project RED: Funded by the [Agency for Healthcare Research and Quality](https://www.ahrq.gov), [National Heart, Lung and Blood Institute](https://www.nhlbi.nih.gov), the [Blue Cross Blue Shield Foundation](https://www.bluecrossblueshrift.org), and the [Patient-Centered Outcomes Research Institute](https://www.pcori.org).*
• In addition to interventions discussed here today, let’s also look at approaches to advance care planning and end-of-life conversations.
Advance Care Planning

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Chief Medical Officer
Mariner Healthcare Central
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Chief Medical Officer, Mariner Healthcare Central
President-Elect and Past President, CALTCM
Editor-in-Chief, Caring for the Ages
www.caringfortheages.com
Past Chair, Coalition for Compassionate Care of CA
Public Policy Director, AMDA—The Society for Post-Acute & Long-Term Care Medicine;
Board of Directors: San Diego County Medical Society
Medical Director: Carlsbad by the Sea Care Center,
Hospice by the Sea, Life Care Center of Vista
Objectives

- Describe advance care planning and who should participate in it
- Appreciate the importance of advance care planning (ACP) for adults of all ages
- Understand where POLST fits into the spectrum of planning ahead in the nursing facility setting—and who should complete POLST
- Implement strategies to improve the ACP process to reduce unnecessary hospitalizations and rehospitalizations
The Nexus of ACP and (Re)Hospitalizations

- Failure to provide and abide by advance care planning documents and **POLST** can result in unnecessary hospitalizations
- Poor communication about prognosis and risks/benefits of interventions can also impact it
- Fear of liability may prompt nurses to clamor for transfer in cases where it may not truly be necessary—or docs/NPs/PAs to order transfer
People don’t like talking about these subjects.

Americans seem to believe that death is optional, and that science and technology can keep anyone alive.

TV doesn’t help: almost everyone survives CPR, and people routinely awaken and regain normal function after decades in a coma.

But these are really important subjects to consider! Thinking ahead and talking about it can prevent a lot of physical & emotional pain.

We have some bad habits in nursing facilities around POLST.
What is Advance Care Planning?

Collaborative process between health care providers, patients & and family (surrogates, agents, others) to make decisions about future health care concerns, even though periods of incapacity.

- Thinking through one’s values and preferences.
- Talking about one’s values and preferences.
- Documenting them and sharing the information.
  - Made “in advance”—not “advanced”
Why is Advance Care Planning Important?

- Puts a person’s wishes in writing
- Increased communication among patient, family, health care team
- Allows for the person to get as much or as little information as they want
- Helps assure that they get the care they want to get, and don’t get the care they don’t want to get!
Why is Advance Care Planning Important?

- Reduces stress on family members when making difficult decisions
- Creates realistic expectations about what the future holds—we can help with that!
- Allows person to choose the best person to speak on their behalf when they can’t speak for themselves—very important to choose correctly!
Advance Health Care Directive (AHCD)

- Includes Durable Power of Attorney for Healthcare
- Allows person to name agent(s) to make medical decisions for them
- Recommended for everyone over 18!
  - But less than 30% of the public has done this
- General statements of goals of treatment, although can write in specific do’s and don’ts
- Doesn’t require attorney, notary or doctor
  - Just 2 witnesses to your signature who aren’t parties
  - Except in a nursing facility: Requires Ombudsman witness
  - We should be doing more of these~!
Serious Illness Deserves Serious Conversations

- Many tools available for discussing medical condition, prognosis, available interventions
- Formal training can be helpful
- Don’t count on your physicians or NPs to be experts on this. If they are, that is a bonus.
- If you have clinicians (or staffers!) who seem to have a very high incidence of full code/full care, investigate the reason for this
- Engage your medical director in ensuring appropriate conversations are occurring
Decision Guides from CCCC

CPR • Tube Feeding • Hydration • Ventilator

What is CPR?
CPR is an attempt to re-start the heart when someone:
- has stopped breathing and the heart stops beating,
- has a type of heart attack that leads to no pulse and death.

What is Tube Feeding?
Tube feeding is when someone needs to nourish their body because they cannot eat or cannot swallow.

What is Hydration?
Hydration is the process of providing fluids to the body through oral intake, IV fluids, or other means.

What is Ventilator?
A ventilator is a machine that helps people breathe when their own lungs cannot function on their own.

What is Artificial Hydration?
Artificial hydration is the process of providing fluids to the body through IV fluids.

Tube feeding is

- A feeding tube can be placed through the nose into the stomach, or
- Placed surgically into the esophagus to bypass the stomach, or
- Placed surgically through the skin into the stomach or intestines.

Hydration

- A person who is dehydrated can:
  - Have a rounded face, sunken eyes, dry skin, and thirst
  - Be less able to think clearly
  - Be tired and weak
  - Have digestive problems
  - Have dry mucous membranes
  - Have dry urine

CPR

- CPR is performed after the heart stops beating
- CPR can be performed on someone who is conscious or unconscious
- CPR can be performed on someone who is breathing or not breathing

Ventilator

- A ventilator is a machine that helps people breathe when their own lungs cannot function on their own.
- Parameters that can be controlled include:
  - Ventilator settings
  - Airflow
  - Pressure
  -潮气量
  -Heart rate
  - Blood pressure
  - Oxygen saturation
  - Urine output

How does CPR work?
CPR is performed on the chest to re-start the heart.

When to Use CPR?
CPR should be performed on someone who:
- Has stopped breathing and the heart stops beating
- Has a heart attack that leads to no pulse and death

When is Tube Feeding Necessary?
Tube feeding is necessary when someone:
- Has difficulty swallowing
- Has a medical condition that makes eating difficult
- Is unable to eat due to illness or injury

When is Artificial Hydration Necessary?
Artificial hydration is necessary when someone:
- Has difficulty drinking
- Has a medical condition that makes drinking difficult
- Is unable to drink due to illness or injury

When is a Ventilator Necessary?
A ventilator is necessary when someone:
- Has difficulty breathing
- Has a medical condition that makes breathing difficult
- Is unable to breathe due to illness or injury

http://coalitionccc.org/tools-resources/decision-guides/
POLST

- Physician’s Orders for Life Sustaining Treatment
- Grass roots movement, many stakeholders
  - Coalition for Compassionate Care of California is the lead organization for POLST in the state
  - Great resources on website www.caPOLST.org
- Movement started in Oregon about 20 years ago
- California has had an endorsed POLST program since 2009 (now 30+ states)
  - Other states have different names/acronyms/colors
  - POST, COLST, MOST, MOLST, etc.
POLST

- Bright pink form, it’s a portable doctor’s order
- Nobody is mandated to fill out or sign a POLST
  - If they don’t, it is assumed that they want the most aggressive and invasive treatment
- Designed for people nearing the end of life
  - “Surprise” question, chronically ill (“Would you be surprised if this person died within a year?”)
  - Requires signature of patient (or surrogate), and doctor or NP/PA
- More than just a piece of paper or checklist: should reflect a rich conversation about goals
POLST and AHCDs

- **POLST** is not just for DNR status—also applies to people who want the most aggressive life-prolonging measures possible
- Meant to **complement** an advance health care directive (AHCD/DPOAHC), not replace it
  - They should say the same basic thing (be concordant)
  - If they conflict, the one done more recently takes precedence
  - Currently being challenged with new legislation (AB 937)
- Very important that both reflect actual, current values and goals to the extent possible
**Section A of POLST**

**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.

<table>
<thead>
<tr>
<th>Patient Last Name:</th>
<th>Date Form Prepared:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient First Name:</td>
<td>Patient Date of Birth:</td>
</tr>
<tr>
<td>Patient Middle Name:</td>
<td>Medical Record #: (optional)</td>
</tr>
</tbody>
</table>

**A**  
**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)
Patient has died a natural death
  - No heartbeat
  - Not breathing

**Important** for people to know that checking DNR/AND does not mean “Do Nothing” in situations short of a full cardiac and respiratory arrest

Useful to know that CPR is very ineffective in frail elderly patients, and can cause serious harm for those who survive
CPR Success Rates

- 14% overall survival in hospitals
- <10% on general medical wards
- 80% of those with restored rhythm do not regain consciousness
- 0-3% survival rates in Skilled Nursing Facilities
  - Most never regain normal function or ability to walk
- On TV: Success rate is like 90%! 
Section B – Full Treatment

- Full Treatment
  - Full use of all hospital has to offer
    - Including ICU & intubation/ventilation, dialysis, etc.
  - Invasive, intense, aggressive
- CPR = most invasive/aggressive intervention
  - Those choosing CPR in Section A must choose Full Treatment in Section B
- Can be for trial period, either a specific time or just left blank and defer to decisionmaker
  - This is what most people who desire full treatment want (trial period, not forever)
### 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:** __________________________________________

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### 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:** __________________________________________
Section B – Selective Treatment

- Selective Treatment
  - Most complex category
  - Not ready for comfort ONLY, but want less invasive treatment
    - No ventilator / intubation
    - Think twice before surgery or ICU
    - Treat treatable conditions if not too burdensome
    - What many people would consider “No Heroics”

- Do Not Transfer option
  - Acknowledges residents who want these treatments in nursing home or assisted living, but not hospital—but still must transfer if comfort needs can’t be met in current setting
Comfort-Focused Treatment

- Everyone gets comfort care
  - Whether box is checked or not
- Choice is mostly for patients close to the end of life—interventions designed to prolong life generally not wanted
- Don’t send to hospital unless comfort can’t be managed in current location (designed for SNFs)
- Change in condition – Evaluate
  - For example, broken hip may need surgery to address pain, which promotes comfort
Studies have demonstrated that patients who complete POLST are more likely to receive care that is concordant with their wishes.

- Less transfers to hospital
- More care in place, more hospice/palliative interventions
- Higher satisfaction with care
- Education around bad outcomes associated with ED and hospitalization can also help
  - We can provide high-level interventions in our facilities
  - For LTC residents, staff know them well
Many SNFs hand out POLST as part of the admission packet, and for practical purposes “require” its completion: STOP THIS!

- Multiple AFLs from CDPH have been sent out

Clearly very valuable for some patients, but not appropriate for everyone

Questions about quality of POLST conversations and validity of the POLST completion process in some SNFs (including finding AHCD and getting ombudsman involved when appropriate)
Forms are sent to hospital and never returned
Nurses/docs send patients to hospital who shouldn’t be sent based on their goals of care
People do not realize that “DNR” does not mean “let the patient die” and take less action than appropriate
Family members sign forms when patient has capacity
Forms not sent home with patient or faxed to PCP
New POLST filled out every admission despite no changes to wishes or goals of care
Pt. has just completed POLST at hospital and brought it, but SNF requires pt. fill out a new one – sometimes with different orders!
Ramifications as to rehospitalization are obvious — if someone wants comfort-focused care or checks “do not transfer to hospital,” that effectively prevents readmits.

Many conditions can be treated in the SNF. Educating about risks of hospital can help.

ACP also helps respect patients’ wishes and allows them not to be subjected to unwanted and ineffective interventions (e.g., CPR—or tube feeding in dementia)
Dying of dehydration is not a bad way to go. It’s better than many of the alternatives. But patients do not know this unless we tell them.

We must always respect their goals of care, but educate patients and families. So they can make informed decisions.

Do NOT make every resident complete a POLST!
For All You Do!

Thank You!
Questions?
Register Now for Upcoming Webinars

COACHING CALL

RRPP Coaching Call

Tuesday, April 3, 2018
12 noon PT

INTERVENTION STRATEGIES

Change in Condition: Heart Failure, Anticoagulants, and Medication Reconciliation

Wednesday, April 25, 2018
11 a.m.–12 noon PT

www.hsag.com/events
Thank you!

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Chief Medical Officer
Mariner Healthcare Central
For continuing education credit (1), please complete the evaluation at:

https://goo.gl/9j6vM5

If you registered online for this event, you will also receive the link via email.

A recording of today’s session will be available at:

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(Click on today’s event date to access the recording link)
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