



END-OF-LIFE CARE IN NEW JERSEY HOSPITALS

A Blueprint for Action



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EXECUTIVE SUMMARY

In New Jersey patients near the end of life are treated with more aggressive medical care than in any other state in the United States. This is best evidenced in the Dartmouth Atlas of Healthcare. However, there is little evidence that readily demonstrates whether the medical outcomes are improved. Put simply, it is likely that patients in New Jersey may be “over treated” at the end of life without objective evidence that there is a corresponding benefit.

This difference in care deserves the attention of all New Jersey citizens. It raises legitimate concerns regarding patient autonomy and patient self-determination at the end of life. Patients have a right to participate fully in all healthcare decisions, and near the end of life this becomes enormously important. Accordingly, physicians and institutional healthcare providers must be prepared to honestly present the burdens and benefits of medical treatment in the end stages of illness. It is only with this information that patients and their surrogate decision-makers can make meaningful, personal choices regarding end-of-life care. It also is important that patient decisions are protected in a vehicle that is readily recognized and honored in all treatment settings. Such a vehicle will assure that there is consistent treatment of patients irrespective of the setting and that the patient’s care preferences will travel with the patient and be readily recognized by all involved healthcare providers.

It is these two concerns, assuring respect for patient rights and communicating patient preferences at the end of life that prompts the medical leadership of the hospitals in New Jersey to recommend action. This Blueprint sets forth a set of actionable steps to assure that patient preferences regarding end-of-life care are assessed regularly and that the patient decisions are communicated effectively to all healthcare providers. These recommendations are intended to extend to hospitals and all other patient care settings with the goal of affording patients multiple opportunities to record their preferences and/or alter prior preferences as their health status changes.

In New Jersey patients at the end of life are treated with more aggressive medical care than in any other state in the United States.

RECOMMENDATIONS

RECOMMENDATION 1: Hospitals, skilled nursing facilities, long term care institutions and assisted living facilities should implement processes to better identify and address end-of-life care issues.

RECOMMENDATION 1A: At the time of admission to a hospital, skilled nursing facility, long term care institution or assisted living facility, patients at risk for an end-of-life care event must be assessed regarding end-of-life care decision-making. The patient decisions and treatment preferences with respect to end-of-life care must be recorded in a standard document that is recognized and readily understood by all future care providers.

A physician/nurse practitioner/physician assistant or other appropriately qualified healthcare professional will assess all patients at risk for an end-of-life event upon admission to a hospital, skilled nursing facility, long term care institution or an assisted living facility. The assessment will focus on end-of-life care preferences including risks and benefits of any current treatment or reasonably foreseeable future care. The purpose of the assessment is to capture specific documentation of the patient's goals regarding current and potential future care for the condition including:

- The types of present or reasonably foreseeable care deemed acceptable or unacceptable to the patient
- Do Not Resuscitate (DNR) preferences
- Do Not Hospitalize (DNH) preferences
- Life-sustaining medical treatment preferences
- Advance directives and
- Pain management preferences.

Patient characteristics may place a patient at risk of death and triggering an end-of-life care assessment. These characteristics may include:

- (i) Adults admitted to a critical care bed for three or more days in the same month
- (ii) Adults who are readmitted to the hospital for three or more times within 12 months for the same or similar chronic condition
- (iii) All patients admitted to a long-term care unit or a skilled nursing facility for a chronic condition (incorporating their assessment as part of the first interdisciplinary care patient conference)
- (iv) Adults admitted to an assisted living facility.

RECOMMENDATION 1B: It should be understood that discussions regarding end-of-life care should occur long before a terminal hospitalization. Understanding, however, that many such discussions occur for the first time in critical care settings, New Jersey hospitals should consider implementing intensivist physician staffing models in their intensive care units. Critical care boarded and trained physicians are experienced in end-of-life discussions. Such physician staffing models also ensure more consistent availability of this expertise, better coordination of care and more consistent communication with family members.

RECOMMENDATION 2: New Jersey should adopt legislation and enabling regulations to address end-of-life care issues in New Jersey.

RECOMMENDATION 2A: New Jersey should adopt legislation and enabling regulation to support uniform Medical (or Physician's) Orders for Life Sustaining Treatment (MOLST/POLST) that are transportable and recognized in all healthcare and ambulatory settings.

RECOMMENDATION 2B: Efforts should also begin to determine the feasibility of legislation regarding futile medical care similar to the Texas legislation. The Texas Advance Directive's Act (1999) describes certain provisions that are now Chapter 166 of the Texas Health & Safety Code. Section 166.046, subsection (e) allows a healthcare facility to discontinue life-sustaining treatment against the wishes of the patient or guardian ten days after giving written notice if the continuation of life-sustaining treatment is considered medically inappropriate by the treating medical team.

RECOMMENDATION 3: New Jersey should establish a Statewide Advisory Board on Palliative Care that will serve as a central resource for advancing end-of-life care practices in New Jersey healthcare facilities. The Advisory Board would be made up of appropriate experts to provide leadership to the state on end-of-life care education, training and public awareness needs.

The Advisory Board roles would include:

- (i) Serving as a liaison to government regarding end-of-life care practices in New Jersey
- (ii) Establishing model standards of practice regarding end-of-life care in New Jersey,
- (iii) Serving as an educational resource for healthcare facilities to facilitate the adoption of new practices,
- (iv) Developing best practices to support standard end-of-life care practices in New Jersey's healthcare facilities,
- (v) Developing regional ethics committees in support of advancing patient rights with respect to end-of-life care.
- (vi) Assessing the outcomes of end-of-life care practices in New Jersey to assure that these efforts include advance patient care and patient rights in New Jersey and making recommendations for additional changes when required,
- (vii) Serving as a resource and providing community education around end-of-life care and advance care planning in coordination with consumer groups and religious organizations.

The Advisory Board membership would include, but not be limited to, representatives from the New Jersey Hospital Association, the Medical Society of New Jersey, the New Jersey Bar Association, the Board of Medical Examiners and the New Jersey Department of Health and Senior Services. At a minimum there should be one physician with a specialty in palliative care.

RECOMMENDATION 3A: New Jersey should develop and implement a transportable set of programs to provide education and support for facilities advancing their end-of-life care and palliative medicine competencies. This would be best accomplished by a single advisory board to assure consistent practices that protect patients.

RECOMMENDATION 3B: New Jersey should establish a mandatory education requirement for licensed health care professionals regarding assessing and communicating end-of-life care needs.

RECOMMENDATION 3C: New Jersey should implement a standard tool for hospitals, skilled nursing facilities, long term care institutions and assisted living facilities that assures that the end-of-life care assessments meet professionally recognized standards of care and that the outcomes are recorded in the medical record and incorporated in the patient's treatment plan.

RECOMMENDATION 4: New Jersey hospitals should develop formal policies that are uniformly followed in New Jersey to address futile medical care. The futile medical care policy would assure that patients and/or their surrogate decision-makers are provided objective information regarding the benefits and burdens of medical care provided to patients and the limitations of that care, as may occur when clinical outcomes indicate that medical care is no longer beneficial and fails to advance a reasonable goal of medical treatment. Defining futile medical care assures that the planned treatment is commensurate with each patient's healthcare goals and that medical care is not used to advance other goals that are not reasonable ends of medical treatment.

BACKGROUND

HISTORICAL PERSPECTIVE

During the 20th century the public perception of hospitals in the United States underwent a remarkable transformation. Little more than 100 years ago, most medical care was still provided in the home. Hospitals were largely regarded as a place where people, particularly the poor and disabled, went to die. However, by the end of the 19th century multiple medical discoveries were just beginning to take hold, and these would greatly advance the reputation of modern medicine. This set the stage for a wholesale change in the public attitude toward hospitals.

Today we are experiencing the benefits of that change, with the public placing an almost inordinate degree of faith in the capability of hospitals to provide restorative care. One consequence is that the limitations of medical science are sometimes misunderstood or blurred, and the public does not appreciate the impact of advanced medical care on individual quality of life. Medicine still has its boundaries and limitations. The tendency is to overestimate the potential medical benefit of advanced healthcare technologies without always giving due consideration to patient wishes and personal concerns. This is especially true in New Jersey, and the potential to over treat is more evident in New Jersey's acute care hospitals than in any other region. There are similar concerns regarding the nature of end-of-life care in the outpatient setting as well.

In New Jersey patients at the end of life are treated with more aggressive medical care than in any other state in the United States. This is evident across many measures. The medical leadership of the hospitals in New Jersey has identified this as a concern that requires action. Put simply, it is likely that medical professionals in New Jersey are "over treating" patients at the end of life without objective evidence that there is a corresponding benefit.

Certainly there are significant concerns regarding patient rights, personal autonomy and professionalism. The greatest concern is that this aggressive style of medicine is not meeting the needs of the citizens of New Jersey. Better understanding the origins of this problem is a key element to understanding why it is now necessary to improve end-of-life care in hospitals. The opportunity today is to first define the problem for the public and to set forth a plan developed by the New Jersey Hospital Association that will lead to education and training to permanently improve the services for patients needing end-of-life care.

This Blueprint for Action is a starting point. It is the product of conscious concerns of physician leaders in New Jersey and a broadening discussion that occurred over the last two years. It is a plan that focuses initially on hospital care, but will by necessity draw outpatient care experts into the solutions. Finally, it entertains the engagement and participation of leaders from the legislative and regulatory ranks because some of the changes will demand the coordinated participation of licensed professionals.

THE HOSPITAL REPUTATION IN PERSPECTIVE

It is difficult to guess whether the advances of the 19th century or those of the 20th century had the greatest impact on modern hospitals. It is clear that the foundations of change began with the Industrial Revolution. The Industrial Revolution provided both the demand for better care and the means for its discovery. People in Europe and in America migrated from the countryside to populate the cities and take

part in the economic opportunities exploding there. With that shift, disease, especially infectious disease, created a public health nightmare. Cholera and typhoid were commonplace; tuberculosis played its role; and factories were often highly dangerous places where worker health was a low priority. Hospitals were not viewed positively. The need for better care was self-evident, but demand alone does not cause discovery. A more plausible explanation for the rapid advances lies in the fact that the Industrial Revolution also provided the physical means for scientific and technologic investigation into the causes and cures of disease. This opened the door to unseen worlds and generated many great medical discoveries: Pasteur (microorganisms), Semmelweis (hand washing), Liston (ether), Lister (aseptic technique), Chamberland (the autoclave), and Landsteiner (safe blood transfusion). Understanding the microbiologic basis for infection and the value of aseptic techniques combined for enormous value. The death rate from surgery in the 1850s fell from 46 percent to as little as 2 percent for some procedures by the end of the century. At the same time, the contributions of nurse reformers (Barton, Nightingale and Seacole) provided tremendous advances in the quality of hospitals. Armed with modern science, the applied nursing care sciences afforded hospital patients much better outcomes. As a consequence, hospitals were positioned to take a different place in the minds of people during the next century. They would not be a place for ignoble death, but a place of rescue and restoration.

During the 20th century hospital reputations grew in importance and stature in our communities. As one infirmity after another was stamped out, it was not unreasonable to conclude that the advances of modern medicine were small miracles. The reputation of the hospital and the public's reliance on them was forever changed. The value to society was enormous. It is difficult to overstate the successes. To the unschooled observer, today's hospitals offer artificial and real replacements for worn out parts, cures from infectious disease, rescue from sepsis, stroke and heart attack, meaningful treatment for psychiatric illness and the means to augment or restore reproductive capacity. Despite the fact that about 70 percent of the care still occurs outside of hospitals, hospitals have become the center of care in the minds of patients. Hospitals are not a place to die, but instead a place that promises and delivers renewal and improved health for many diseases.

At the same time hospitals have become the economic center of many communities across the country. This is also true in New Jersey where some hospitals are amongst the largest employers in the region. Indeed, hospitals are key drivers of the economy and this is not purely the product of medical advancement. The century brought a reversal of the population swings of the prior millennia; people migrated from the cities to the suburbs. Suburban hospitals grew in physical size and technical capability. At the same time, the century also reshaped the nature of the workforce in suburban communities. Communities affected by international economies experienced job losses to foreign countries. Manufacturing jobs left in large numbers, while service sector employment grew more predominant, in some cases only by default. In other cases whole industries have been eliminated by technological advancement. When industries dry up or move to other venues, healthcare often grows in relative importance. In many instances the hospital became the "new" center of town.

Through these struggles, it was always true that hospitals have become important to Americans, and it is not unreasonable for patients to see hospitals symbolically. They are a vessel of hope. They are a place of refuge, relief and restoration. The hospital is vital to public health. Emergency departments are

central to a community's sense of safety and well-being. The religious and not-for-profit origins of hospitals serve to buttress this image. Having a hospital is the mark of a thriving community. It should not be surprising that a community rebels when its hospital is slated for closure. The rebellion is not generally an economic one, but more a symbolic and emotional one. Again, in many communities the hospital is the reason for the town. Patients no longer go to hospitals with the expectations of dying, but to the contrary expect, however true, to be restored, to be revitalized and renewed.

THE PARADOX OF HOPE AT THE END OF LIFE

Understanding the patient's expectations of modern hospitals is a good background for appreciating the difficulties of providing end-of-life care. As a result of the success of modern healthcare, patients have high hopes for what hospitals can accomplish. And it is important to acknowledge that patients should have high expectations of care, even at the end of life. Patients should always be afforded truly effective care and it should be delivered timely and efficiently. That cannot be argued.

At the same time, however, a hospital and its medical staff must be prepared to honestly present the burdens and benefits of care at the end of life. It is only with this information that patients and their surrogate decision makers can make meaningful, personal choices.

Communication regarding end-of-life care often occurs too late in the dying process. Patients may have already become incapacitated and unable to participate in decision-making, and families are frustrated by the limited amount of advance guidance available to them. In many institutions physicians and nurses have inadequate or poorly organized resources to address end-of-life care needs. Unfortunately the decision is often presented to the patient as choosing between two options; where option one is doing everything that is medically available to preserve life and option two is not doing that. For too many patients and families the options are understood this way, where second choice is choosing dying. From a medical standpoint this is a tragedy. It suggests medical care can only be one of two things, either beneficial or futile. The paradox suggests that hope only resides in aggressive attempts to extend the quantity of life, altogether neglecting the value for hoping for qualitatively different measures of benefit. The two-option approach fails to organize care around the patient. It ignores patient preferences, personal goals and ethnic differences among patients.

Often hospital teams get caught up in the paradox of preserving hope, providing by default every measure of aggressive care. This is well designed to meet the community expectation of providing all the care that is medically appropriate and preserving of the patient's life. It continues the promise of potential renewal and restoration. It usually meets the standard of medical care. But it does not always serve the patient's interests. What is lacking is an objective and subjective assessment of the "hoped for" outcome. Absent that communication, the potential for the patient to suffer needlessly is great. It also should be noted that continued aggressive care in the setting of ethical futility may not be in accordance with the accepted standard of care and may unfairly place the healthcare professional in an untenable position in which he/she may feel coerced to provide care contrary to professional judgment.

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At times, the patient or the family demand aggressive care without regard to the objective limits to the benefit. The practice is blindly followed because doing something must be better than doing nothing. Dr. Ira Bayock, MD, a longtime palliative care physician and a past president of the American Academy of Hospice and Palliative Medicine, comments that, “Families cannot imagine that there could be anything worse than their loved one dying. But, in fact, there are things worse, most generally having someone you love dying badly ... dying suffering, dying connected to machines.”

Medicine today is capable of offering so much more at the end of life, whether care preferences are collected in the hospital or out of the hospital. Palliative care practitioners and clinicians who specialize in end-of-life care treatment are demonstrating that there are many other paths, some that offer a qualitatively better experience that more closely meets the patient's expectations. It is also clear that decisions near the end of life are almost never a simple choice between two paths, one up and one down. The seeming paradox is that patients still use the hospital expecting recovery and renewal, despite the fact that there is objective evidence of advanced chronic disease. It is difficult to reconcile differences with patients and families whose expectations of recovery continue to grow as the state of disease advances.

The actual paradox is that aggressive medical care is provided when there is little or no objective evidence that there will be meaningful benefit to the patient. In the interest of preserving some hope, aggressive medical care is the default path. An alternative path is to assure that the healthcare team communicates regarding the limitations of aggressive treatment. Medicine is limited, and there often is a predictable beginning to the end of life. This is vitally important to share. No one wants to die with unrelieved pain, nor does one want to suffer the indignities of medical care that is not honest or, worse yet, holds out false hopes about the future. There can be a good death to mark the end of a great life. The patient and surrogate decision-maker should be afforded the opportunity to make decisions regarding life-extending medical care that also preserves the subjective needs, those of quality of life.

Today there is a place for improving end-of-life care.

END-OF-LIFE CARE IN NEW JERSEY IS DIFFERENT

The Dartmouth Atlas of Healthcare provides evidence that strongly supports the conclusion that end-of-life care provided in New Jersey is both quantitatively and qualitatively different than that provided in other states. For more than 20 years, the Dartmouth Atlas Project has documented variations in how medical resources are distributed and used in the United States. Often the results are glaring. The project uses Medicare data to provide comprehensive information and analysis about national, regional and local markets, as well as individual hospitals and their affiliated physicians.

The Dartmouth Atlas study demonstrates across multiple measures that New Jersey patients experience more aggressive care at the end of life without evidence to suggest that there is corresponding medical benefit. In fact, across many measures New Jersey patients receive more aggressive care than in any other state, ranking first in order of magnitude of resource consumption, often by large margins. In many instances the

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difference between the state with the highest resource consumption and the state with the lowest resource consumption exceeds a factor of 2:1. That means that by some measures patients in New Jersey receive more than twice as much care than is provided in other states. The reason for this is not clear.

In the table below the measures in which the care in New Jersey exceeds the cost or intensity of all other states is summarized. It is difficult to avoid the conclusion that care provided to Medicare beneficiaries in New Jersey nearing the end of life is significantly more intense than that provided in other states. It is important to note, however, that the Dartmouth Atlas data does not measure the medical outcomes of care, but only measures the resources that are consumed. One might debate that New Jerseyans receive better care and have better outcomes as a result of the practice patterns, but there is little evidence to support the proposition.

DARTMOUTH ATLAS MEASURE	NEW JERSEY RANK
Total Medicare reimbursements per enrollee during the last two years of life	1
Total Medicare reimbursements during the last six months of life	1
Inpatient reimbursements per decedent during the last two years of life	1
Inpatient reimbursements per decedent during the last six months of life	1
Outpatient reimbursement per decedent during the last two years of life	1
Average co-payments per decedent for physician services during the last two years of life	1
Total FTE primary care physician labor inputs per 1,000 decedents during the last two years of life	1
Total FTE medical specialist labor inputs per 1,000 decedents during the last two years of life	1
Hospital days per decedent during the last two years of life	1
Total ICU days per decedent during the last two years of life	1
High-Intensity ICU/CCU days per decedent during the last two years of life	1
Total physician visits per decedent during last two years of life	1
Medical specialist visits per decedent during the last two years of life	1
Primary care physician visits per decedent during the last two years of life	1
Percent of decedents seeing 10 or more different physicians during the last six months of life	1
Number of different physicians seen per decedent during the last six months of life	1

A CALL FOR COORDINATED ACTION

During the last two years the Physician Executive Constituency Group (PECG) of the New Jersey Hospital Association has discussed end-of-life care practices in New Jersey, especially as they relate to hospitals. This group is comprised of physician leaders whose professional work is to oversee the medical staffs

of the hospitals in New Jersey and meets to discuss issues of common interest. There was much discussion regarding the aggressive character of end-of-life care practice in New Jersey, including discussion of reasons and barriers that might account for the strikingly high utilization patterns (see Appendix A). Some of these considerations included the high rate of litigation and fear of malpractice; the high density of medical education resources in the tri-state area and that physicians are not trained to be passive; economic incentives that encourage aggressive care; and the fact that sometimes physicians just give in when confronted by demanding families and patients — even when the objective evidence suggests that care being rendered is futile — and provide care until patients expire. Nonetheless, these factors were not unique to New Jersey. The PEEG determined that there was still a large gap in the competencies of hospitals and clinicians treating patients at the end of life.

Palliative care is distinguished among clinical specialties in acknowledging that dying is a normal part of the life of every individual and every family.

A conference in February 2009 was organized to clarify the challenges of end-of-life care in New Jersey. It was attended by physician leaders of New Jersey's hospitals, nurse leaders with expertise in end-of-life care and palliative care, and leading authorities on palliative care medicine. The purpose of the conference was to review the end-of-life care practices in New Jersey and create a template for change. The conference concluded that there was a significant gap in the end-of-life care capabilities in New Jersey when compared to peer states. Perhaps more importantly, the conference recognized that there was a tremendous variation between hospitals with respect to the skills and resources available to serve the needs of dying patients. Some hospitals had active palliative care teams that were already managing patients using advanced approaches, while other hospitals reported that there was no expertise available in their facilities.

The conference garnered strong support for advancing the use of palliative care practitioners in New Jersey. This was supported by a general sense that there was large unserved need. Palliative care affirms life and regards dying as a natural process that is a profoundly personal experience for the individual and family. For every patient, eventually the focus shifts to the process of dying. There should be corresponding shift in emphasis to end-of-life decision-making and achieving a death that is consistent with the values and expressed desires of the patient. This opportunity often is lost. There was recognition that this is an area for improvement in New Jersey.

Palliative care is distinguished among clinical specialties in acknowledging that dying is a normal part of the life of every individual and every family. Palliative care neither hastens nor postpones death, but rather seeks to relieve suffering, control symptoms and restore functional capacity while remaining sensitive to personal, cultural and religious values, beliefs and practices. Palliative care guides patients and families as they journey through the changing goals of care and helps the patient who wishes to address issues of life completion and closure.

The recommended action steps that follow emerged from the conference as key elements to improving end-of-life care practices in New Jersey.

RECOMMENDATIONS AND SUPPORT

RECOMMENDATION 1: Hospitals, skilled nursing facilities, long term care institutions and assisted living facilities should implement processes to better identify and address end-of-life care issues.

RECOMMENDATION 1A: At the time of admission to a hospital, skilled nursing facility, long term care institution or assisted living facility, patients at risk for an end-of-life care event must be assessed regarding end-of-life care decision-making. The patient decisions and treatment preferences with respect to end-of-life care must be recorded in a standard document that is a recognized and readily understood by all future care providers.

A physician/nurse practitioner/physician assistant or other appropriately qualified healthcare professional will assess all patients at risk for an end-of-life event upon admission to a hospital, skilled nursing facility, long term care institution or an assisted living facility. The assessment would focus on end-of-life care preferences including risks and benefits of any current treatment or reasonably foreseeable future care. The purpose of the assessment is to capture specific documentation of the patient's goals regarding current and potential future care for the condition including:

- The types of present or reasonably foreseeable care deemed acceptable or unacceptable to the patient
- Do Not Resuscitate (DNR) preferences
- Do Not Hospitalize (DNH) preferences
- Life sustaining medical treatment preferences
- Advance directives, and
- Pain management preferences.

Patient characteristics may place a patient at risk of death and triggering an end-of-life care assessment. These characteristics include:

- (i) Adults admitted to a critical care bed for three or more days in the same month
- (ii) Adults who are readmitted to the hospital for three or more times within 12 months for the same or similar chronic condition
- (iii) All patients admitted to a long-term care unit or a skilled nursing facility for a chronic condition (incorporating their assessment as part of the first interdisciplinary care patient conference)
- (iv) Adults admitted to an assisted living facility.

Alternatively, and currently part of the initiative in Rhode Island to improve end-of-life care in intensive care units, is a policy whereby all ICU patients are screened, with the exceptions being

- Post-op from elective surgery with expected ICU admission
- ICU stay of <24 hours
- Patients boarded in the ICU
- Psychiatric/suicide admissions, e.g. overdose, suicide attempt.

Central to improving the quality of care at the end of life is to assure that patients are active participants with their healthcare providers in anticipating and making end-of-life care decisions. This screening requirement triggers screening of patients at the greatest risk for an end-of-life event. While this assessment may be done on any patient, the requirement is designed to focus on those patients whose clinical course suggests that advanced stage disease may be present or that there is a higher risk of dying. An assessment of a patient's goals has proportionately greater value and meaning for patients with these risk factors.

Many of the assessment processes that patients undergo at the time of admission to hospitals or other healthcare facilities have grown from similar efforts to improve care. These have included screening for abuse, identifying nutritional deficits, identifying advanced directives, assessing allergies and identifying communicable diseases, to name a few. Each of these efforts was designed to fill gaps in the continuum of care for the patient in that facility. By establishing a new standard for assessing a patient's end-of-life care preferences, New Jersey improves patient services by assuring that the patient's care preferences are updated regularly and honored across a broad continuum of care settings.

This recommendation to assess targeted patients is based on the fact that there are physiologic changes and care events that herald the need for considering end-of-life care. The recommendation is not exclusive, but makes an assessment compulsory where certain screening criteria are met. The recommendation calls for a set of standard procedures to be established and followed in all New Jersey hospitals, skilled nursing facilities, long term care institutions and assisted living facilities. It is anticipated that an advisory board will be created to assist the state in setting up the parameters of an appropriate end-of-life care assessment. The advisory board would also be responsible for monitoring outcomes and making recommendations for improvement (*See below*).

This recommendation also envisions that hospitals and healthcare facilities will need to identify key members of the staff to provide end-of-life care consultation and management. The new requirement contemplates an additional process in the continuum of care, but is designed to maximize patient rights. Once trained, these persons could serve as leaders of practice changes in their institutions and assist in implementing a broad improvement in end-of-life care in New Jersey¹.

RECOMMENDATION 1B: It should be understood that discussions regarding end-of-life care should occur long before a terminal hospitalization. Understanding, however, that many such discussions occur for the first time in critical care settings, New Jersey hospitals should consider implementing intensivist physician staffing models in their intensive care units. Critical care boarded and trained physicians are experienced in end-of-life discussions. Such physician staffing models also ensure more con-

1 There are already a number of resources available to obtain this training. These include ELNEC (End-of-Life Nursing Consortium) for nurses and the EPEC Project (Education in Palliative and End of Life Care) for physicians. These programs also offer "train the trainer" options to help disseminate the message. They require a commitment of time to attend. They prove very useful for developing institutional leaders and facilitating care improvement.

There are other resources for educators. The EPERC (End of Life/Palliative Education Resource Center) project at the University of Wisconsin supports individuals involved in the design, implementation and evaluation of End-of-Life/Palliative education for physicians, nurses and other healthcare professionals. The project Web pages (<http://www.eperc.mcw.edu>) are designed for use by medical school course/clerkship directors, residency and continuing education program directors, medical faculty, community preceptors or other health professionals who are (or will be) involved in providing EOL instruction to healthcare professionals in training.

sistent availability of this expertise, better coordination of care and more consistent communication with family members.

RECOMMENDATION 2: New Jersey should adopt legislation and enabling regulations to address end-of-life care issues in New Jersey.

RECOMMENDATION 2A: New Jersey should adopt legislation and enabling regulation to support uniform Medical Orders for Life Sustaining Treatment (MOLST) that are transportable and recognized in all healthcare and ambulatory settings.

Many states already have adopted regulations supporting Medical Orders for Life Sustaining Treatment (MOLST) or Physician Orders for Life Sustaining Treatment (POLST) standards. These efforts provide for one document that is used to record a patient's end-of-life care preferences. This document protects all patients. MOLST assures that patients who want aggressive care receive it. MOLST also assures that patients who do not want aggressive care or who do not want cardiopulmonary resuscitation have their preferences followed. Essentially MOLST advances patient rights and makes the patient's wishes more easily followed by all healthcare providers.

There are two key differences between MOLST and New Jersey's current tools for communicating end-of-life care preferences, which include Advance Directives, New Jersey's current Out of Hospital Do Not Resuscitate (OHDNR) Orders and in-hospital/healthcare facility DNR orders. First, MOLST orders would be recognized and binding on all New Jersey healthcare providers (physicians, nurses, EMS personnel) in all settings. MOLST orders use a common form that would be standardized in all settings. There is an additional advantage in the fact that MOLST forms follow a national standard and out-of-state recognition would be provided to patients in states supporting MOLST. Second, MOLST is transportable. It doesn't need to be rewritten or renewed unless the patient changes preferences. MOLST eliminates the necessity for separate inpatient and outpatient resuscitation orders. MOLST orders are pro-patient and reduce uncertainty for patients. MOLST also reduces the burden of healthcare personnel charged with assessing patients, most particularly when the patient is no longer able to make decisions.

RECOMMENDATION 2B: Efforts also should begin to determine the feasibility of legislation regarding futile medical care similar to the Texas legislation.

RECOMMENDATION 3: New Jersey should establish a Statewide Advisory Board on Palliative Care that will serve as a central resource for advancing end-of-life care practices in New Jersey healthcare facilities. The Advisory Board would be made up of appropriate experts to provide leadership to the state on end-of-life care education, training and public awareness needs.

The advisory board roles would include:

- (i) Serving as a liaison to government regarding end-of-life care practices in New Jersey
- (ii) Establishing model standards of practice regarding end-of-life care in New Jersey,
- (iii) Serving as an educational resource for healthcare facilities to facilitate the adoption of new practices,
- (iv) Developing best practices to support standard end-of-life care practices in New Jersey's healthcare facilities,

(v) Developing Regional Ethics Committees in support of advancing patient rights with respect to end-of-life care.

(vi) Assessing the outcomes of end-of-life care practices in New Jersey to assure that these efforts advance patient care and patient rights in New Jersey and making recommendations for additional changes when required.

(vii) Serving as a resource and providing community education around end-of-life care and advance care planning in coordination with consumer groups and religious organizations.

There also is a need for a central resource comprised of persons with interest and expertise in end-of-life care that leads improvement efforts in New Jersey hospitals and outpatient care venues. The group would be comprised of leaders in the field who would strive to make a broad impact in advancing end-of-life care services across the continuum of healthcare.

The advisory board membership would include, but not be limited to, representatives from the New Jersey Hospital Association, the Medical Society of New Jersey (see *Appendix B*), the New Jersey Bar Association, the Board of Medical Examiners and the New Jersey Department of Health and Senior Services as well as representatives of community, public and religious organizations as appropriate. At a minimum there should be one physician with a specialty in palliative care. The initial focus would be developing and providing education and training. The group would need to take a leadership role in overcoming barriers. This would require the development of a more detailed understanding of the gaps particular to New Jersey and posing solutions, either regulatory or legislative, to overcome them.

RECOMMENDATION 3A: New Jersey should develop and implement a transportable set of programs to provide education and support for facilities advancing their end-of-life care and palliative medicine competencies. This would be best accomplished by a single advisory board to assure consistent practices that protect patients.

Expanding the knowledge base regarding end-of-life care options is vital to achieving durable changes in practice. This Blueprint assumes that New Jersey care outcomes at the end of life are different and that there is an opportunity for education and change in care practices. This recommendation envisions a mobile resource that would be made available to facilities implementing programmatic changes. Similar resources for self-study, support of independent projects and other experts would comprise a battery of options that could be called upon by interested hospitals, skilled facilities, hospices and long-term care facilities.

There are several goals that need to be addressed through an educational resource. First, there are numerous myths and misunderstandings regarding end-of-life care that need to be clarified. For instance, “Do Not Resuscitate” orders continue to be misused as a statement regarding the patient’s goals with respect to choosing aggressive clinical care. Second, New Jersey is ethnically diverse. Each culture bears different personal, cultural and spiritual practices related to end-of-life care. Establishing a strong foundation in this area is important to success in reaching these communities.

Finally, the recommendation envisions re-examining the language of end-of-life care. Much of the language of death emerges from the belief that everyone is rescued by default, and by implication not rescuing patients is to do something sub-standard. It has been suggested that orders like “Do Not Resuscitate” be

replaced with AND-Allow Natural Death. Similarly, “futile care” suggests falsely that all interventions are fruitless. Using the term “non-beneficial medical care” may be less threatening to patients and families than the phrase “futile care.” In fact, there is a place for “Advanced Illness Management” near the end of life. Using this alternative term also is less threatening to patients. A comprehensive well-designed program will address these elements as well as concerns relative to legal issues and whether tort reform is needed.

RECOMMENDATION 3B: New Jersey should establish a mandatory education requirement for licensed healthcare professionals regarding assessing and communicating regarding end of life care needs.

It is proposed that New Jersey add a requirement for education on end-of-life care assessments, communication tools and patient rights that would facilitate adoption of the practices contemplated here. A one-time mandatory education program, with continuing education credits applicable to licensure requirements and tailored for different skill groups, would have a broad impact by assuring that new tools are understood by all healthcare professionals. Education also facilitates implementation of the use of the tools in appropriate settings with added expertise and compassion.

Hospitals also could contemplate changes requiring mandatory participation in ethics conferences or end-of-life care planning conferences.

RECOMMENDATION 3C: New Jersey should implement a standard tool for hospitals, skilled nursing facilities, long term care institutions and assisted living facilities that assures that the end-of-life care assessments meet professionally recognized standards of care and that the outcomes are recorded in the medical record and incorporated in the patient’s treatment plan.

By developing a standard assessment tool, the quality of end-of-life care assessments will be enhanced. A standard tool will assure that the scope of the assessment is appropriate and complete. It also assures that the outcomes of the assessment are more easily incorporated in the patient’s treatment plan when a patient moves from one care setting to another.

RECOMMENDATION 4: New Jersey hospitals should develop formal policies that are uniformly followed in New Jersey to address futile medical care. The futile medical care policy would assure that patients and/or their surrogate decision-makers are provided objective information regarding the benefits and burdens of medical care provided to patients and the limitations of that care, as may occur when clinical outcomes indicate that medical care is no longer beneficial and fails to advance a reasonable goal of medical treatment. Defining futile medical care assures that the planned treatment is commensurate with each patient’s healthcare goals and that medical care is not used to advance other goals that are not reasonable ends of medical treatment.

Patients would benefit from having a uniform policy addressing futile care. By standardizing the terminology, providing standard processes for recognizing and assessing futile care and then incorporating this assessment in clinical decision-making, management of patients with serious illness would be enhanced. Importantly, it also would establish standard practices upon which futile care could be withheld or withdrawn. Standardization would assure greater acceptance by the community and facilitate consistent practices.

NJHA endorses a Futile Care Template Policy (see *Appendix C*) that advances new standards of performance for assessing care that may be futile. It is recognized that futile care is difficult to define and

that futile care has different meanings for different cultures. However, it is not difficult to define futile medical care. A futile care policy would be designed for hospital medical staffs to incorporate within their bylaws, rules and regulations or medical staff policies. It would be designed so that it is scalable and thus attainable in each of New Jersey's acute care hospitals. The goal would be to gain adoption of uniform futile care practices by hospital medical staffs. Elements of futile care assessment and end-of-life care are closely intertwined. Support for successfully implementing changes in futile care practices would include the following support elements:

- Model Medical Staff bylaws or policies addressing futile medical care.
- Model changes to Medical Staff bylaws or rules and regulations that would support mandatory palliative care consultation based on certain triggers.
- Guidelines for developing a section of palliative care medicine and suggested resources for encouraging existing medical staff members to become expert in palliative care and to begin providing palliative and end-of-life care consultation services as a focus of expertise.
- Model credentialing standards for persons who request privileges as palliative care practitioners on the medical staff. The model standards would provide support for persons with different clinical backgrounds and skill sets to develop expertise.
- Model policies and procedures to support mandatory end-of-life care assessments outlined above. These would be designed to dovetail on end-of-life care assessments, MOLST/POLST orders and Advance Directives.

ⁱ Ira Byock, MD, "60 Minutes," November 22, 2009. Dr. Byock is director of palliative medicine at Dartmouth-Hitchcock Medical Center in Lebanon, N.H. and a professor of anesthesiology and community and family medicine at Dartmouth Medical School.

ⁱⁱ The Dartmouth Atlas of Healthcare (<http://www.dartmouthatlas.org>), 2001-2006 data.

Approved by the
NJHA PHYSICIAN EXECUTIVE CONSTITUENCY GROUP
July, 2010



APPENDIX A

BARRIERS TO EFFECTIVE MANAGEMENT OF END-OF-LIFE ISSUES

- Professional education lacking/physician skill set in this area variable.
- End-of-life discussions time consuming and sometimes confrontational. Often multiple meetings needed with multiple family members.
- Physician reimbursement lacking for this time consuming process.
- Financial incentives favor ongoing treatment as opposed to withholding or withdrawing care.
- Medical-legal concerns/fears for withholding/withdrawing life sustaining treatment at end-of-life.
- Medical care fragmented at end-of-life often with involvement of multiple specialty consultants. Often a defined and willing “captain of the ship” is lacking. This is especially prevalent in the ICU setting.
- Communication to families by multiple physicians is often incomplete, contradictory (mixed messages), or does not address end-of-life options.
- End-of-life discussions often occur late in the process (acute hospitalization) rather than in a more controlled and less threatening setting (office).
- Focus on technology in modern health care.
- Unrealistic expectations on the part of the public (i.e. sentiment that high-technology health care can restore health and function in all situations).
- Financial disincentives to enroll patients in hospice programs.
- May need to explore cultural differences in end of life care for both physicians and patients/families in NJ.



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WORK GROUP ON CARE AT THE END OF LIFE
FINAL REPORT
TO THE MSNJ POLICY & STRATEGY COMMITTEE

October 15, 2009

Joseph Fennelly, MD, Chair
Lawrence Downs, Staff

The Policy & Strategy Panel (PSP) established a work group to examine the delivery of healthcare to patients at the end of life. This topic was introduced to the panel by Fred Jacobs, MD, JD at the October 2008 meeting of the PSP.

The workgroup was formed by the members of MSNJ's Bioethics Committee and other interested physician members. The committee sought to understand other efforts by organizations that are engaged in the topic and to develop and recommend policy statements for consideration by the PSP, and ultimately the MSNJ Trustees.

The work group met on December 10, 2008 and January 27, 2009. In addition the group met with representatives of the NJ Bar Association on January 22, 2009 to discuss legal impediments to providing optimal care at the end of life.

Work group members are continuing to educate themselves on current issues in end of life care. Several members attended the NJHA/MSNJ symposium on February 18, 2009 and will attend and be speakers at the upcoming conferences on April 18, 2009 at St. Barnabas and May 12, 2009 at Stockton College/South Jersey Ethics Alliance.

The work group has invited participation by AARP, private nursing homes, the ombudsman, and is particularly grateful for the collaboration with the NJHA (Aline Holmes) and the medical directors.

Final Policy Recommendations

Transfers from long term care facilities

The work group acknowledges that elderly unaccompanied patients that are transferred from long term care facilities are difficult cases. More attentive transfer of the unaccompanied patient from *any setting* to the hospital is important to provide high quality end of life care.

Over a decade ago the Medical Society approved an “out of hospital DNR” form and process. Presently there is no central location for these forms. Also there are some issues with ambulance and EMT personnel in terms of ongoing education in using this process.

MSNJ should advocate that patients transferred from long term care facilities to hospitals should be transferred with a care plan and goals of care. Also each long term care facility should routinely transfer patients with advance directives included with the transfer paperwork.

POLST/ MOLST Legislative/ or regulatory initiative

Code status, advanced directive and orders of palliative care can be combined by New Jersey adapting an inclusive form already available in many states. This is entitled “Physician (Medical) Orders for Life Sustaining Treatment”– also known as POLST. This form goes with the patient: from acute to chronic care or vice versa. Currently DNR orders do not follow the patient from home to a care setting or between care settings.

The format is such that it emphasizes a positive approach- rather than “do NOT resuscitate” or treat. It defines the comfort measures subsumed under palliative care. MSNJ supports this shared approach to end of life care.

Regional Ethics Committees

MSNJ supports the re-newel and training of regional ethics committees to provide decision support to institutions, health professionals, patients and families in a shared decision making framework. This lending of support to all involved can reduce the fear of legal sanctions. New Jersey has an existing framework that can support the renewal of regional ethics committees. This policy statement should include support for modest government funding to ensure proper training and continuing education for regional ethics committee members and support for communications.

A number of hospital ethics committees in Monmouth and Union County lend support to nursing homes in these matters, but it is not codified or commonly known.

Legal research & writing

MSNJ supports the development of legal guidance to physicians and healthcare institutions about potential liability for the type, extent and intensity of care provided to patients at the end of life.

In discussions with the NJ State Bar Association the work group has learned that there is an increased likelihood of suits for “wrongful life” rather than wrongful death. Moreover, the legal community does not hold the same perception of potential litigation in these matters that is held by the physician community. However there is clear recognition that even the slight perception of liability will drive defensive decision-making.

Based on the outcome of the legal research, MSNJ should consider supporting any regulatory or legislative reforms that will protect physicians who engage in good practice.

The legal group was responsive to distributing advanced directives to whomever their clients designated –particularly to the personal physician, as well as those persons having medical power of attorney. This would require education so that attorneys recognize that it would not contravene the privacy involved in handling regular wills.

Academic training

The work group recognized the need to provide better training for physicians. MSNJ supports:

- a. Palliative care at the end of life included as part of the basic training for new physicians
- b. Educators and other health professionals should initiate changes in undergraduate, graduate, and continuing education to ensure that practitioners have the relevant attitudes, knowledge, and skills to care well for dying patients.

[Note: In initial contact with the UMDNJ Dean of Clinical Affairs and faculty there is a genuine willingness to create dialogue on this topic.]

Palliative Care

The Medical Society supports the development of palliative care teams in hospitals as well as long term care facilities and assure that palliative care consults occur early in the hospital stay for patients that are appropriate candidates. Palliative care specialist physicians and teams can improve symptom and pain relief and improve patient / family / care team communication.


Continuing Education for Physicians

MSNJ encourages continuing education for its members on communication techniques with families and proper referral to palliative care for patients. It is recognized that many physicians are not prepared to have end of life care plan discussions with patients and their families. MSNJ should arrange for education and support for members in this area.

Cultural issues for both physicians and the public can bridge both factors of diversity and more proportional and compassionate end-of-life care. For example St. Barnabas is hosting a meeting with speakers: 1. Dr. Timothy Quill who took the issue of physician assisted dying to the US Supreme court as well as 2. Dr. Robert Like, the highly respected expert in cultural issues.


Advance directives warehouse

MSNJ supports and encourages the ability to “warehouse” advance directives in an electronic format for easy access to these important healthcare planning documents at critical times. MSNJ should develop a dialogue with hospitals, the state bar, and other stakeholders (AARP) to create a registry where citizens can forward their healthcare planning documents.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY													
 EMSA #111 B (Effective 1/1/2009)	<h2 style="margin: 0;">Physician Orders for Life-Sustaining Treatment (POLST)</h2> <p style="font-size: small;">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. Everyone shall be treated with dignity and respect.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Last Name</td> </tr> <tr> <td style="padding: 2px;">First /Middle Name</td> </tr> <tr> <td style="padding: 2px;">Date of Birth Date Form Prepared</td> </tr> </table>	Last Name	First /Middle Name	Date of Birth Date Form Prepared								
Last Name													
First /Middle Name													
Date of Birth Date Form Prepared													
A Check One	CARDIOPULMONARY RESUSCITATION (CPR): <i>Person has no pulse and is not breathing.</i> <input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (<u>A</u> llow <u>N</u> atural <u>D</u> eath) (Section B: Full Treatment required) When not in cardiopulmonary arrest, follow orders in B and C .												
B Check One	MEDICAL INTERVENTIONS: <i>Person has pulse and/or is breathing.</i> <input type="checkbox"/> 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. Antibiotics only to promote comfort. Transfer if comfort needs cannot be met in current location. <input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> Do Not Transfer to hospital for medical interventions. Transfer if comfort needs cannot be met in current location. <input type="checkbox"/> Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care. Additional Orders: _____ _____												
C Check One	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible and desired.</i> <input type="checkbox"/> No artificial nutrition by tube. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. <input type="checkbox"/> Long-term artificial nutrition by tube. Additional Orders: _____ _____												
D	SIGNATURES AND SUMMARY OF MEDICAL CONDITION: Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Health Care Decisionmaker <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Court Appointed Conservator <input type="checkbox"/> Other: 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. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; padding: 2px;">Print Physician Name</td> <td style="width: 30%; padding: 2px;">Physician Phone Number</td> <td style="width: 30%; padding: 2px;">Date</td> </tr> <tr> <td style="padding: 2px;">Physician Signature (required)</td> <td colspan="2" style="padding: 2px;">Physician License #</td> </tr> </table> Signature of Patient, Decisionmaker, Parent of Minor or Conservator 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. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 2px;">Signature (required)</td> <td style="width: 33%; padding: 2px;">Name (print)</td> <td style="width: 34%; padding: 2px;">Relationship (write self if patient)</td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 2px;">Summary of Medical Condition</td> <td style="width: 40%; padding: 2px;">Office Use Only</td> </tr> </table>		Print Physician Name	Physician Phone Number	Date	Physician Signature (required)	Physician License #		Signature (required)	Name (print)	Relationship (write self if patient)	Summary of Medical Condition	Office Use Only
Print Physician Name	Physician Phone Number	Date											
Physician Signature (required)	Physician License #												
Signature (required)	Name (print)	Relationship (write self if patient)											
Summary of Medical Condition	Office Use Only												
SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED													

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			
Patient Name (last, first, middle)		Date of Birth	Gender: M F
Patient Address			
Contact Information			
Health Care Decisionmaker	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared
<p style="text-align: center;">Directions for Health Care Professional</p> <p>Completing POLST</p> <ul style="list-style-type: none"> • Must be completed by health care professional based on patient preferences and medical indications. • POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy. • Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly. • Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. <p>Using POLST</p> <ul style="list-style-type: none"> • Any incomplete section of POLST implies full treatment for that section. <p>Section A:</p> <ul style="list-style-type: none"> • No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation." <p>Section B:</p> <ul style="list-style-type: none"> • When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). • IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only." • Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations. • Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment." <p>Reviewing POLST</p> <p>It is recommended that POLST be reviewed periodically. Review is recommended when:</p> <ul style="list-style-type: none"> • The person is transferred from one care setting or care level to another, or • There is a substantial change in the person's health status, or • The person's treatment preferences change. <p>Modifying and Voiding POLST</p> <ul style="list-style-type: none"> • A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form. • To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date this line. • A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interests. <p>This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.</p> <p style="text-align: center;">For more information or a copy of the form, visit www.capolst.org.</p> <p style="text-align: center;">SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED</p>			

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY						
<h2 style="margin: 0;">Physician Orders for Life-Sustaining Treatment (POLST)</h2>						
<p>FIRST follow these orders, THEN contact physician, nurse practitioner or PA-C. 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. Everyone shall be treated with dignity and respect.</p>		<p>Last Name /First/Middle Initial _____</p> <p>Date of Birth _____ Last 4 #SSN _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F</p>				
A	Check One	<p>CARDIOPULMONARY RESUSCITATION (CPR): <u>Person has no pulse and is not breathing.</u></p> <p><input type="checkbox"/> CPR/Attempt Resuscitation <input type="checkbox"/> DNR/Do Not Attempt Resuscitation (Allow Natural Death)</p> <p>When not in cardiopulmonary arrest, follow orders in B, C and D.</p>				
B	Check One	<p>MEDICAL INTERVENTIONS: <u>Person has pulse and/or is breathing.</u></p> <p><input type="checkbox"/> COMFORT MEASURES ONLY Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer: EMS contact medical control to determine if transport indicated to provide adequate comfort.</p> <p><input type="checkbox"/> LIMITED ADDITIONAL INTERVENTIONS Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care if possible.</p> <p><input type="checkbox"/> 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.</p> <p>Additional Orders: (e.g. dialysis, etc.) _____</p>				
C	Check One	<p>ANTIBIOTICS:</p> <p><input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms.</p> <p><input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs; with comfort as goal.</p> <p><input type="checkbox"/> Use antibiotics if life can be prolonged.</p> <p>Additional Orders: _____</p>	<p>D</p> <p style="text-align: center;">Check One</p> <p>ARTIFICIALLY ADMINISTERED NUTRITION: <u>Always offer food and liquids by mouth if feasible.</u></p> <p><input type="checkbox"/> No artificial nutrition by tube.</p> <p><input type="checkbox"/> Trial period of artificial nutrition by tube. (Goal: _____)</p> <p><input type="checkbox"/> Long-term artificial nutrition by tube.</p> <p>Additional Orders: _____</p>			
E	<p>MEDICAL CONDITION/GOALS:</p>					
F	<p>SIGNATURES: <u>The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information:</u></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; padding: 5px;"> <p>Discussed with:</p> <p><input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor</p> <p><input type="checkbox"/> Legal Guardian</p> <p><input type="checkbox"/> Health Care Agent (DPOAHC)</p> <p><input type="checkbox"/> Spouse/Other: _____</p> </td> <td style="width: 30%; padding: 5px;"> <p>PRINT — Physician/ARNP/PA-C Name</p> <hr/> <p>Physician/ARNP/PA-C Signature (mandatory)</p> <hr/> <p>Patient or Legal Surrogate Signature (mandatory)</p> </td> <td style="width: 30%; padding: 5px;"> <p>Phone Number</p> <hr/> <p>Date</p> <hr/> <p>Date</p> </td> </tr> </table>			<p>Discussed with:</p> <p><input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor</p> <p><input type="checkbox"/> Legal Guardian</p> <p><input type="checkbox"/> Health Care Agent (DPOAHC)</p> <p><input type="checkbox"/> Spouse/Other: _____</p>	<p>PRINT — Physician/ARNP/PA-C Name</p> <hr/> <p>Physician/ARNP/PA-C Signature (mandatory)</p> <hr/> <p>Patient or Legal Surrogate Signature (mandatory)</p>	<p>Phone Number</p> <hr/> <p>Date</p> <hr/> <p>Date</p>
<p>Discussed with:</p> <p><input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor</p> <p><input type="checkbox"/> Legal Guardian</p> <p><input type="checkbox"/> Health Care Agent (DPOAHC)</p> <p><input type="checkbox"/> Spouse/Other: _____</p>	<p>PRINT — Physician/ARNP/PA-C Name</p> <hr/> <p>Physician/ARNP/PA-C Signature (mandatory)</p> <hr/> <p>Patient or Legal Surrogate Signature (mandatory)</p>	<p>Phone Number</p> <hr/> <p>Date</p> <hr/> <p>Date</p>				
<p>SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED</p>						
<p>Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid</p>						

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY			
Other Contact Information (Optional)			
Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number	
Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared
Person has: <input type="checkbox"/> Health Care Directive (living will) <input type="checkbox"/> DPOAHC <input type="checkbox"/> Living Will Registry		Encourage all advance care planning documents to accompany POLST	
DIRECTIONS FOR HEALTH CARE PROFESSIONALS			
Completing POLST <ul style="list-style-type: none"> • Must be completed by health care professional. • Should reflect person's current preferences and medical indications. Encourage completion of an advance directive. • POLST must be signed by a physician/NP/PA to be valid. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy. • Use of original form is encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. 			
Using POLST <i>Any incomplete section of POLST implies full treatment for that section.</i>			
SECTION A: <ul style="list-style-type: none"> • No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation." 			
SECTION B: <ul style="list-style-type: none"> • When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). • An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only." • Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment." 			
SECTION D: <ul style="list-style-type: none"> • Oral fluids and nutrition must always be offered if medically feasible. • A person with capacity or the surrogate of a person without capacity, can void the form and request alternative treatment. 			
Reviewing POLST This POLST should be reviewed periodically whenever: <ol style="list-style-type: none"> (1) The person is transferred from one care setting or care level to another, or (2) There is a substantial change in the person's health status, or (3) The person's treatment preferences change. To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.			
Review of this POLST Form			
Review Date	Reviewer	Location of Review	Review Outcome
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED			
			

Revised December 200

FUTILE MEDICAL TREATMENT IN TERMINALLY ILL PATIENTS

[INSERT NAME OF HOSPITAL]
ADMINISTRATIVE POLICY & PROCEDURES

POLICY NUMBER: _____ EFFECTIVE DATE: _____

SIGNED COPY OF FILE

APPROVED BY: _____ DATE: _____

DATE: _____

DATE: _____

ATTACHMENTS: None

PURPOSE: At [Insert name of hospital], physicians and other members of the treatment team provide high quality medical care to all patients within the framework of the values and goals of patients and the legitimate boundaries of medical science. To that end, the purpose of this policy is to define and address the use of Futile Medical Treatment to terminally ill patients and to describe a process for handling disputes related to the provision of Futile Medical Treatment in specific circumstances.

This policy should be implemented in accordance with the following [Insert name of hospital] policies:

Advance Directives
Do Not Resuscitate
Foregoing Life-Sustaining Treatment
Brain Death
Palliative Care Policy (*Where such policy exists*)

NO ACTION SHALL BE TAKEN WHICH
CONTRADICTS ANY OF THE ABOVE REFERENCED POLICIES.

DEFINITIONS

FUTILE MEDICAL TREATMENT: For purposes of this policy, Futile Medical Treatment shall mean life-sustaining medical treatment or procedures for a patient with a Terminal Condition (defined herein) where one or more of the following categories is met: (1) the proposed LSMT is likely to be ineffective or futile in prolonging life; (2) the proposed LSMT is likely to merely prolong an imminent dying process; (3) the patient is in a Terminal Condition (as defined herein), as determined by the attending physician and confirmed by a second qualified physician; (4) the patient has a serious irreversible illness or condition, and the likely risks and burdens associated with the medical intervention to be withheld or withdrawn may reasonably be judged to outweigh the likely benefits to the patient from such intervention; (5) the patient has a serious irreversible illness or condition, and imposition of the medical intervention on an unwilling patient would prove inhumane; and/or (6) the proposed LSMT is experimental, unproven therapy. A determination of whether a specific LSMT is futile requires dialogue between the attending physician, appropriate consulting physician(s), other members of the healthcare team and the patient/the patient's Surrogate Decision Maker (defined herein). When an LSMT is deemed futile and the patient/Surrogate Decision Maker request the initiation of said futile LSMT and/or do not consent to the withholding or withdrawal of futile LSMT, refer to the Conflict Resolution Section of this policy.

LIFE-SUSTAINING MEDICAL TREATMENT (LSMT): The use of any medical device or procedure, artificially provided fluids and nutrition, drugs, surgery or therapy that uses mechanical or other artificial means to sustain, restore or supplant a vital bodily function, and thereby increase the expected life span of a patient.

PALLIATIVE CARE: A holistic approach to individual care, integrating medical, psychosocial, and spiritual elements, in the presence of an incurable progressive illness that is expected to end in death. Palliative care is designed to decrease the severity of pain, suffering, and other distressing symptoms, and to provide for the patient's comfort and dignity. Palliative care recognizes that dying is part of living. Palliative care is provided to the individual, the family, and others involved in the individual's illness by an interdisciplinary healthcare team, including nurses, social workers, chaplains, and physicians. The expected outcome of palliative care is to enable the individual to experience an improved quality of life at the end of life.

SURROGATE DECISION MAKER: Someone appointed to act on behalf of another to make decisions only when an individual is without decision making capacity or has given permission to involve others. The Surrogate Decision Maker must be an adult (at least 18 years old). The following shall be the order of priority for determining who may serve as a Surrogate Decision Maker:

- A court-appointed guardian.
- The health care representative designated by the patient's Advance Directive.
- A close and caring family member or a domestic partner. A "family member" shall mean, in order of priority, the resident's spouse in a marriage or a civil union, adult son/daughter, parents, or next of kin (brothers/ sisters, grandchildren, grandparents, aunts/uncles, nieces/nephews or cousins). A "domestic partner" is "Domestic partner" or "partner" means a person who is in a relationship that satisfies the definition of a domestic partnership set forth in N.J.S.A. 26:8A-4(b). A civil union

is described at N.J.S.A. 37:1-30 and shall be determined in accordance with **[Insert title of Hospital's Civil Union Policy]**.

- Another person who functions as the patient's family if no close family member is available; provided, however, that where a person other than an individual identified in subsection (c) above is functioning as a Surrogate Decision Maker, the Risk Manager or legal counsel must be contacted to confirm whether such person may serve in such capacity.

TERMINAL CONDITION: The terminal stage of an irreversibly fatal illness, disease or condition. A determination of a specific life expectancy is not required as a precondition for a diagnosis of a "terminal condition," but a prognosis of a life expectancy of six (6) months or less, with or without the provision of life-sustaining treatment, based upon reasonable medical certainty, shall be deemed to constitute a terminal condition.

POLICY

I. FUTILE MEDICAL TREATMENT: Steps 1 through 5 of this Section I must be followed when a physician recommends against instituting or continuing Futile Medical Treatment.

1. It is the policy of **[Insert name of hospital]** that physicians have the right and responsibility to recommend against instituting or continuing Futile Medical Treatment for patients who have a Terminal Condition. The treating physicians (attending and/or consulting physicians) shall discuss medical options with the patient or, where applicable, the patient's Surrogate Decision Maker. In the event of a disagreement between any of the physicians and the patient/Surrogate Decision Maker, refer to the Conflict Resolution Section of this policy.
2. If the attending physician and/or any consulting physician are uncertain as to whether a treatment is a Futile Medical Treatment, the physician(s) may consult with the Bioethics Committee and may request a second opinion from an Additional Physician (defined below). The result of the Bioethics consultation and/or the second opinion shall be documented in the patient's chart in the Progress Notes section. Notwithstanding the foregoing, where Futile Medical Treatment may be withheld or withdrawn, the wishes of an incapacitated patient with an advance directive must be honored in accordance with **[Insert name of hospital]** Advance Directives Policy. "Additional Physician" is defined as a physician: (i) with medical staff privileges at **[Insert Name of Hospital]**; and (ii) who practices in a field related to the patient's underlying illness.
3. Decisions about Futile Medical Treatment must be documented in the patient's medical record. In addition, the following discussions should be held with the patient or, where applicable, the Surrogate Decision Maker:
 - Patient/patient's Surrogate Decision Maker will be informed of the patient's medical condition, prognosis, and treatment options.
 - The patient's values and goals shall be discussed to ensure that the patient's dignity as well as the patient's social, psychological and spiritual well-being is respected. The patient's autonomy will be respected and treatment will be consistent with his/her known values and goals.
 - Where the patient is incapacitated, the patient's previously expressed values should be discussed

with the patient's Surrogate Decision Maker and other family and friends. These discussions must be documented in the patient's medical record.

- The need for Palliative Care for the purpose of providing comfort and relieving suffering shall also be addressed and documented in patient's chart.
4. Where a patient lacks decision making capacity as determined in accordance with **[Insert name of hospital]** Foregoing Life-Sustaining Treatment Policy, and where that patient does not have an advance directive that addresses the Futile Medical Treatment to be withheld or withdrawn, the Bioethics Committee and/or an Additional Physician shall be consulted for confirmation of the appropriateness of any decision by a Surrogate Decision Maker to withdraw or withhold treatment that has been deemed to be Futile Medical Treatment. Documentation related to the consultation with the Bioethics Committee and/or with additional physician(s) must be placed in the patient's chart in the Progress Notes section. In the event of a disagreement between any of the physicians and/or the Bioethics Committee, refer to the Conflict Resolution Section of this policy.
 5. If applicable, the attending and/or treating physician should consider Palliative Care for the patient. A decision to forego Futile Medical Treatment is not a decision to abandon care, but rather a decision to change the goals and modalities of treatment. The goal of Palliative Care is to enhance the quality of life remaining for the patient, while supporting the patient's dignity and autonomy. This requires planning an individual palliative care program for the patient through comprehensive discussions between the treatment team and the patient or, where applicable, the Surrogate Decision Maker. The following steps should be taken where Palliative Care is ordered for a patient:
 - A palliative care program shall be designed to meet the individual needs of each patient. In designing such a program, various palliative treatments shall be discussed with the patient or, where applicable, the patient's Surrogate Decision Maker.
 - Documentation of the palliative care plan must be entered in the patient's chart.
 - It is appropriate for the physician(s) managing the Palliative Care of a patient with a Terminal Condition to review the prognosis of imminent and inevitable death on a regular basis and to reorient care toward life preservation and restoration of function if this becomes appropriate.

II. CONFLICT RESOLUTION

1. Conflict resolution is indicated in all cases where the patient/Surrogate Decision Maker, and the treating and/or consulting physicians disagree as to whether a treatment is Futile Medical Treatment and/or the patient's prognosis.
2. When conflict exists, an order to withhold or withdraw Futile Medical Treatment must not be written and care will not be withheld during the conflict resolution process.
3. If the physician(s) reasonably believes that a treatment is Futile Medical Treatment, and the patient/Surrogate Decision Maker requests that such Futile Medical Treatment be rendered to the patient, a number of approaches are available. Any or all of the following may be made mandatory:

- The physician(s) may seek confirmation that the intervention is Futile Medical Treatment by consultation with one or more members of the attending medical staff; including consultation with a specialist where appropriate;
- The physician(s) may seek consultation with the department chairperson or the applicable section chief;
- Meetings may be held with the patient and, where the patient consents or is incapacitated, with the patient/Surrogate Decision Maker. Support may be provided by clergy, the social service department and/or patient representatives;
- An ethics consultation with the Bioethics Committee may be held.

Notwithstanding the above, if there is any conflict between the physician(s) and the patient or, where applicable, the Surrogate Decision Maker, Paragraphs 4, 5, 6 and 7 of this Section II must be followed.

4. An ethics consultation with the Bioethics Committee shall be held if not already held pursuant to Paragraph 3(d) above.
5. If a patient lacks decision-making capacity and has no advance directive or legally appointed Surrogate Decision Maker, the risk manager and/or the administrator on-call, must be contacted to determine whether it is necessary to seek court intervention to appoint a legal guardian or special medical guardian for the patient. The Risk Manager/administrator on call should contact the Legal Department.
6. If the conflict remains irreconcilable, and a Bioethics Committee has not resolved the conflict, the attending physician, the patient or, where applicable, the Surrogate Decision Maker may seek, where reasonable and feasible, either: (a) an alternate attending physician willing to treat the patient; or (b) the transfer of the patient to another institution willing to treat the patient.
7. If an attending or treating physician declines to personally render Futile Medical Treatment, the physician shall clearly communicate to the patient or, where applicable, the patient's family/Surrogate Decision Maker, the physician's decision not to personally render Futile Medical Treatment. The details of that discussion shall be fully documented in the patient's medical record. In addition, the Physician shall also notify the Risk Manager of his/her decision not to personally render Futile Medical Treatment. The treating physicians must take reasonable steps to transfer care to an alternate physician(s) or to an alternate institution willing to accept care. An order to withhold or withdraw Futile Medical Treatment must not be written and care will not be withheld during the process of transferring the patient to an alternate physician(s) or to an alternate institution willing to accept the patient and provide the care in dispute.

ORIGINAL DATE: _____ REVIEWED: _____

AUTHOR: Bio-Ethics Committee

LOCATION: *Administrative Policy and Procedure Manual;*
Employee Communication Portal –
Administrative Folder

***Related Policies:** Advance Directives, Brain Death, Do Not Resuscitate,
Foregoing Life-Sustaining Treatment