Health Facility Palliative Care Requirement

Health Facility Palliative Care Programs

The Council is positioned to identify the elements of a palliative care program and provide guidance in program development within health facilities. Evaluation and monitoring of health facilities is beyond the scope of this Council, as there are mechanisms in place through the health facility survey process.

The Council is able to encourage the use of best practices when building palliative care programs. The Council may consider education targeted at state surveyors on what is an acceptable palliative care program and what is acceptable care planning for palliative care for purposes of evaluation and monitoring.

The Council as a part of the established Council Objectives will act to "Support health facilities compliance with SB 608(5) and institute a mechanism for effecting meaningful change in areas where delivery of palliative care programs can be improved."

Palliative Care and Health Facilities in Oregon Administrative Rules

The council shall consult with and advise the director on:

(a) Matters related to the establishment, maintenance, operation and evaluation of palliative care initiatives in this state; and
(b) The implementation of ORS 413.273 (Palliative care for patients and residents of hospitals, long term care facilities and residential care facilities).

A health facility shall:

(a) Establish a system for identifying patients or residents who could benefit from palliative care;
(b) Provide information to patients, residents and their families about palliative care; and
(c) Coordinate with a patient's or resident's primary care provider, if practicable, to facilitate the access of patients and residents with serious illnesses to appropriate palliative care. [2015 c.789 §5]

Definition of Palliative Care – Per CMS Rule
73 FR 32204, June 5, 2008 Medicare Hospice Conditions of Participation – Final Rule
"Palliative care means patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice."

Palliative Care includes:

- Palliative Care is appropriate at any age and at any stage in a serious illness
- Expert management of pain and other uncomfortable symptoms
- Ease transitions between care settings (such as hospital, nursing facility, home)
- Facilitate the goal of quality of life
- Focus on the whole person: body, mind, spirit and culture
- Help educate patients and families about prognosis, health care options, establish realistic care goals
- Identify community resources to meet patient goals
- Facilitate communication between patient, family members, and health care providers
- Team approach to care involving all disciplines (physicians, nurses, social workers, spiritual care providers, therapists, pharmacists)

Conditions Where Palliative Care Applies, includes, but is not limited to:

- Cancer
- Heart disease (heart failure, coronary disease)
- Lung disease (emphysema, pulmonary fibrosis)
- Dementia
- Parkinson's Disease
- Stroke
- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- AIDS
- Kidney Failure
- No specific diagnosis, but not doing well "Failure to Thrive"

Stratifying the Need for Palliative Care:

- Frailty
- High Hospital Utilization
- Need for assistance in three or more activities of daily living

Foundations of Palliative Care

- Advance Care Planning is important
- Patients and families need help with coordination of care and services
- Medical care should be delivered based on the patient's goals and values

Relationship of Palliative Care to Hospice

- Hospice is both a philosophy and a health care reimbursement system
    - Restrictions on eligibility (< 6 months prognosis)
    - Restrictions on treatments (focus on comfort)
- Hospice is a subset of palliative care, for patients who meet the hospice eligibility requirements.

Palliative Care Program Goals

- Interdisciplinary and team-based collaboration to facilitate care delivery
- Realistic patient and family-centered care goals
- Reevaluation throughout the duration of illness
- Empowering patients and families about their healthcare choices (never restricting choices)
- Providing for interactions and revisions of goals along the continuum of care for the duration of the illness
    - Continuity of care with indicators established for when to readdress goals
    - Clinical responsibility to review and address
- Expert symptom and comfort management
    - Whether pursuing aggressive life prolonging care or comfort measures only
    - Independent of prognosis
    - Physical, emotional and spiritual symptoms (i.e., pain, dyspnea, nausea and other symptoms)
    - Anxiety and depression
        - Individual and family symptom management secondary to coping
- Care is delivered with cultural humility
- Develop seamless care flows for patients with advanced illnesses throughout regional health care systems including reevaluation of goals of care along the continuum
- Collaboration
    - Regional physicians, practices and community programs
    - Palliative Care Programs
    - Hospice and other Home Health Programs
    - Health Care Facilities
    - Other agencies and resources

Palliative Care Key Elements

Emphasis should be for primary palliative care approach in which the primary care provider has the conversation with patient about Advance Directives and goals of care to identify surrogate decision maker, Advance Care Planning and completion of an Advance Directive or a POLST, if applicable.

As a part of the admission to a healthcare facility, each resident should be asked if they have a copy of a health care directive and will be encouraged to provide a copy that names the individual's healthcare representative. If not able to provide this type of document:

- Resident is informed of the healthcare surrogate by representative law (ORS 127) in Oregon
- Resident is offered support in completing the Oregon Advance Directive
- If the Resident is not able to complete the document, family will be engaged and informed of the healthcare by representative law (ORS 127)

- Offer a discussion with the individual and family to review any previously completed healthcare directive document to see if views about goals of care have changed
- Create an opportunity for the individual and family to identify additional values about unacceptable health status
    - For example: if I lose my vision, ability to engage with family verbally….
- If there are no available documents, have the individual and family view the POLST video
    - http://www.orpolstregistry.org/oregon-polst-registry/information-for-patients-and-families/multimedia-resources/
- Physician/NP/PA/Naturopathic providers will complete the POLST document consistent with the wishes of the individual and submit to the Oregon POLST Registry, as required by law, unless the opt-out provision has been selected.

Statement for Successful Implementation

Health facilities should have a policy about palliative care that includes the following elements:

- Staff education to improve knowledge of Advance Care Planning and goals of care
- Training of how established expectations of a palliative care program will be implemented
- Available information for patients on palliative care resources within community
- Mechanism to identify patients with serious conditions who would benefit from palliative care
- Opportunity and mechanism for patients to engage in Advance Care Planning, to include:
    - Mechanism to identify decision making capacity framing palliative care cultural and ethnic differences that some cultures may present with
    - Identification of a surrogate decision maker and/or health care representative
    - Identification to establish desired goals of care
- Program to facilitate palliative care between patient, primary care provider and health facility to manage or mediate symptoms to meet goals of care
- Team-based and interdisciplinary approach to the delivery of palliative care services
- Ability to access ethical consultation resources
- Incorporation of elements for clarifying goals of care and Advance Care Planning
- Mechanism to measure compliance and implementation
    - Annual reporting of compliance, quality and performance indicators
    - Each Facility should determine those indicators that are meaningful for the location and facility:
        - Percentage of patients admitted to the facility *who received consideration* for a palliative-care consultation (e.g. for whom a palliative-care triage form or other tool was used upon admission);
        - Percentage of patients who *received* a palliative care consultation;
        - Percentage of patients and families who received information about Palliative care;

- Length of time between request for Palliative Care consult and when consult was done;
- Percentage of Primary Care Physicians who refused to allow their patients to receive a Palliative Care consult
- Family satisfaction survey results for specific question regarding satisfaction with the care their loved one received (e.g. with the level of symptom management achieved).
- Employee satisfaction level and/or turnover rates

ADDENDUM
Advance Care Planning – Key Elements
Advance Directives Elements:

- Advance Directives are legally valid throughout the United States, but Advance Directive laws are state specific
- Do not need a lawyer to complete an Advance Directive
- Advance Directives become legally valid in Oregon as soon as signed in front of the required witnesses or notary
- Emergency medical technicians cannot honor living wills or medical powers of attorney
- The Advance Directive in one state does not always work in another state
- Advance Directives do not expire
- Advance Directives should be reviewed periodically to ensure that they still reflect a person's wishes

- Selecting a Health Care Representative
  - A healthcare agent is someone designated to make medical decisions if, at some future time, a person is unable to make decision
  - Health Care Representatives are typically a close relative or friend or can be a close relative or a personal friend
  - Individual needs to know the person's wishes about medical treatment and be willing to take responsibility to ensure wishes are followed
  - Someone trusted and who understands their decisions
  - Not everyone is able to be an effective agent
  - Wishes regarding end-of-life medical treatment

- Discussions With Health Care Representatives
  - Are there treatments you particularly want to receive or refuse?
  - What are you afraid might happen if you can't make decisions for yourself?
  - Do you have any particular fears or concerns about the medical treatments that you might receive? Under what circumstances?
  - What are your views about artificial nutrition (food) and hydration (fluid)?
  - If your heart stopped, under what circumstances would you want doctors to use CPR to try to resuscitate you?

  - Would you want to receive treatments such as mechanical ventilation, antibiotics, or tube feeding for a time, but have them stopped if there were no improvement in your condition?
    Do you want to receive these types of treatment no matter what your medical condition? On a trial basis? Never?

- Benefits of Having a Health Care Representative
  - The Health Care Representative knows the person and understands their wishes about medical treatments
  - The Health Care Representative can make decisions in unanticipated situations
  - The Health Care Representative has flexibility, especially in changing medical condition
  - The Health Care Representative can interpret the Living Will in situations that were not foreseen.
  - The Health Care Representative can be an advocate

- Preparing an Advance Directive
  - Gather information on the types of life-sustaining treatments available
  - Decide what types of treatment desired or not desired
  - Share end-of-life wishes and preferences with loved ones
  - Complete state specific Advance Directive
  - Can include special requests in Advance Directives such as wishes about organ donation, cremation or burial
  - Make physician and loved ones aware of specific requests so appropriate referrals and arrangements can be made
  - Ask someone to look over the documents to be sure completed correctly
  - Ensure all of the necessary information is included and documents are witnessed properly

- After an Advance Directive is Completed
  - Make several photocopies of the completed documents.
  - Keep the original documents in a safe but easily accessible place, tell others where they are; note on the photocopies the location where the originals are kept.
  - DO NOT KEEP ADVANCE DIRECTIVES IN A SAFE DEPOSIT BOX (Unless it is a copy)
  - Give photocopies to Health Care Representative and alternate Health Care Representative
  - Physicians and any involved persons should have copies
  - Talk to anyone who might be involved in healthcare decision making, including family members, loved ones and healthcare providers

Portability Orders for Life-Sustaining Treatment (POLST) Elements:

- State specific - POLST registry in Oregon – Signed into law in 2009
- Most appropriate for seriously ill persons with life-threatening, terminal illness or advanced frailty
- Makes patients' end-of-life treatment preferences known
- Completed by health care providers and signed by physician, nurse practitioner, physician's assistant or naturopathic physician
- Represents wishes as clear, specific written medical orders
- Voluntary – does not require every patient to have a POLST
    - Intended for patients with advanced illness or frailty
- Remains with patients across care settings (hospital, home, facility)
- DOES require health care professional to submit POLST to Registry when completed (unless patient chooses to opt out)
- POLST needs to be easy to locate

First responders and Hospital Emergency Rooms can call Registry Hotline 24/7 when paper form cannot be found immediately - 1-877-367-7657

- Secure and accurate database housed at OHSU Emergency Communications Center
- OR POLST: http://www.orpolstregistry.org/

Living Will Elements:

- A living will allows a person to document their wishes concerning medical treatments at the end of life
- Before a living will is used to guide medical decision-making, two physicians must certify:
    - The patient is unable to make medical decisions
    - The patient is in the medical condition specified in the state's living will law (such as "terminal illness" or "permanent unconsciousness")

Medical Power of Attorney Elements:

- A medical power of attorney (or healthcare proxy) allows a person to appoint a healthcare agent (or surrogate decision maker), who is authorized to make medical decisions on the patient's behalf
- Before a medical power of attorney goes into effect, a patient's physician must conclude that they are unable to make their own medical decisions