# HONORING PATIENTS: PATIENTS' POLST SELECTIONS COMPARED WITH CARE RECEIVED

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# NO FINANCIAL RELATIONSHIPS TO DISCLOSE

# ADVANCE CARE PLANNING AT KAISER PERMANENTE

- A systematic approach that tailors each advance care planning (ACP) conversation to the patient's state of health

- RNs, MSWs, Physicians and others are offered an 8-hour POLST facilitator training originally modeled on the Respecting Choices' "Last Steps" program; this was adapted to "Advanced Steps."

- ACP activities are termed "Life Care Planning."

- KP adheres to state/national POLST Paradigm recommendation that POLST conversations are reserved for patients in the ~last year of life


# ‘LIFE CARE PLANNING’ VISION & PROMISES

## Vision

All adult Kaiser Permanente members wishes for future medical care are elicited, known, and honored.

## Promises

We promise to:

1. Initiate the conversation
2. Provide assistance with Advance Care Planning
3. Make sure plans are clear
4. Maintain and retrieve these plans
5. Appropriately follow these plans

# WHAT IS A CONCORDANCE REVIEW?

**Concordance Review:**

An objective determination of whether a patient's stated care preferences matched the care actually received.

In this study, we were interested in determining whether patients who had participated in an Advanced Steps (POLST) conversation received concordant care during their final care encounter.

# OPERATIONALIZING "CONCORDANCE"

**Concordance**: Documented care received in setting prior to death was consistent with documented wishes on patient's POLST form or was inconsistent with POLST selections but consistent with agent or patient's verbal guidance.

# WHY USE THIS DEFINITION?

**Concordance:** Care received in **setting prior to death** was consistent with documented wishes on patient's POLST form **or was inconsistent with POLST selections but consistent with agent or patient's guidance.**

- "setting prior to death"
- "discordant with POLST selections but consistent with agent or patient's guidance"

# METHODS: REVIEW OF 300 CHARTS FROM 2015


## How the charts were reviewed:

- We randomly sampled 300 charts of the 3,701 Advanced Steps deaths in 2015.
  - The sample was geographically representative.
- Each chart was reviewed by one of three members of a designated team using a standardized questionnaire.
- Any cases of potential discordance were reviewed by two members of the team.

## What the questionnaire asked:

- Care preferences
  - POLST selections
  - Whether and how preferences changed
  - Agent presence
- Care received
  - Setting of death
  - Level of care received
- Concordance determination

# CHART REVIEW METHODOLOGY: DATA AVAILABLE FOR EACH 'ADVANCED STEPS' DEATH

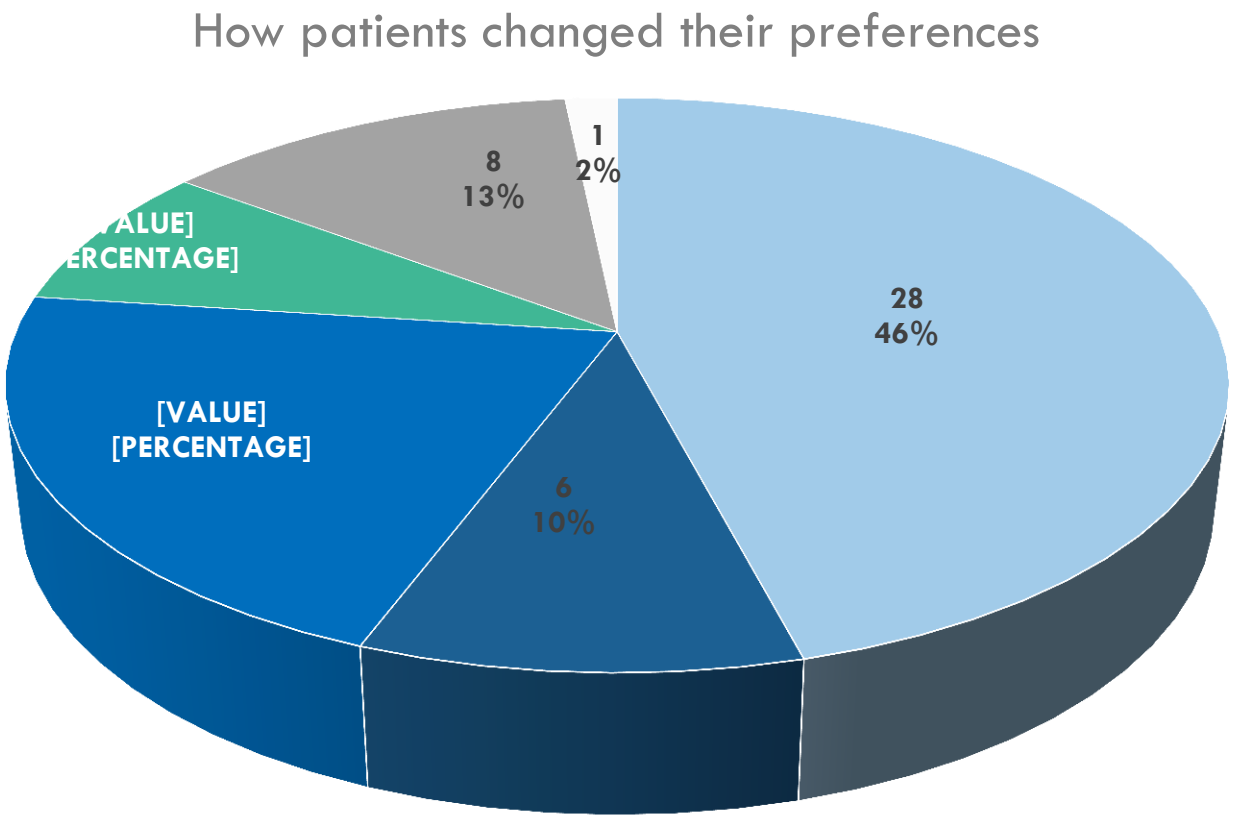
- Patient Name & MRN
- DOB & Date of death
- Medical Center where conversation occurred
- Date of Advanced Steps/POLST conversation
- Whether Agent was present for conversation
- Facilitator name and discipline
- Setting of death: Hospital, ED, SNF/ALF, Home

- Section A POLST selection
- Section B POLST selection
- Section C POLST selection
- Scanned copy of POLST

# FINDINGS | Care Preferences

# 20% OF PATIENTS REVISED THEIR CARE PREFERENCES PRIOR TO DEATH

61 of the 300 charts (20%) involved care preferences that changed after the POLST conversation but prior to death



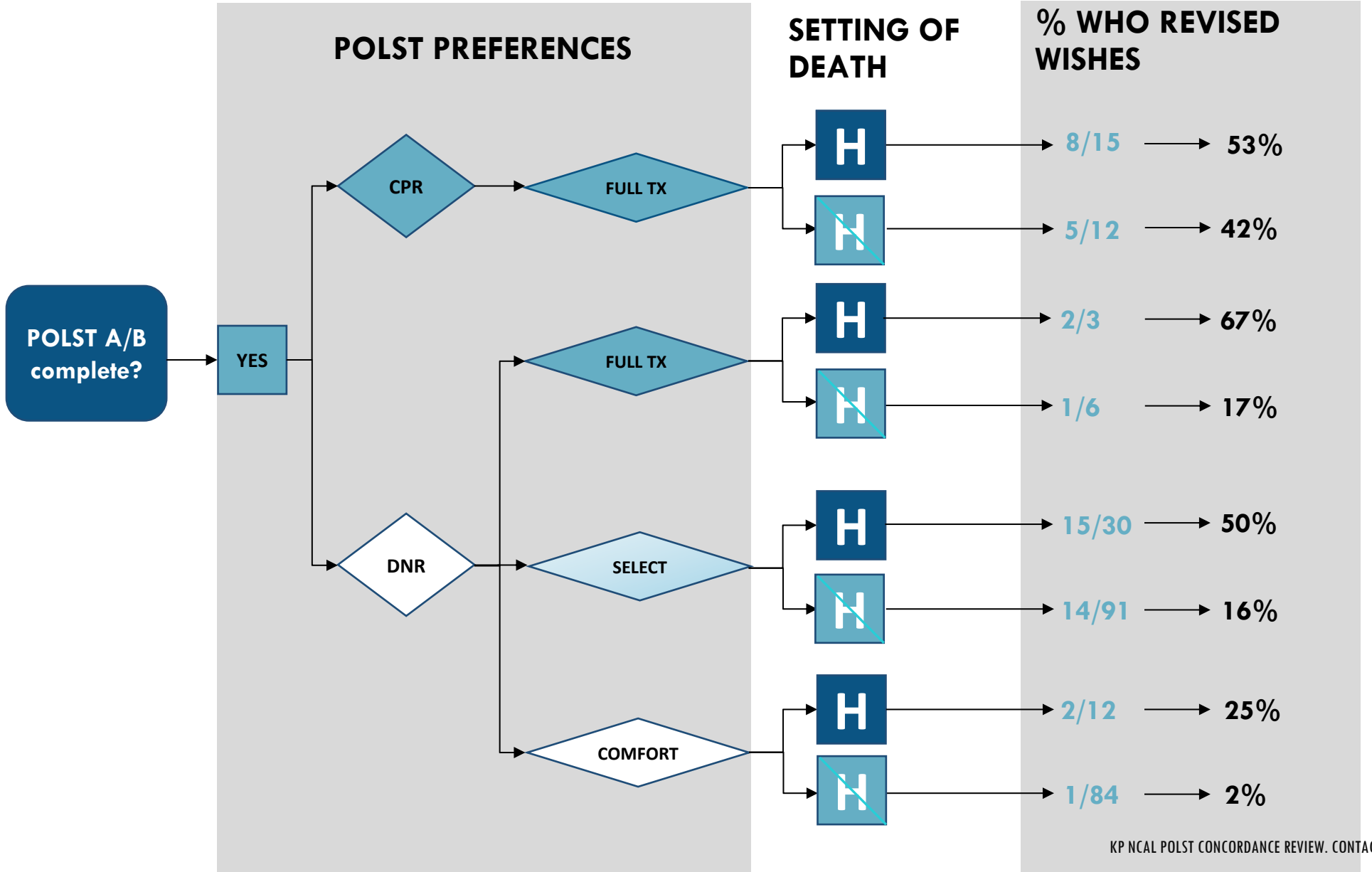
# TIME BETWEEN DATE OF CONVERSATION AND DATE OF DEATH

We found most conversations occurred in the last 12 months of life.

Average time lapse: 125 days

**78%** The patient's Health Care Agent or Surrogate Decision-Maker was present in 235 of 300 conversations.

# WHICH PATIENTS CHANGED THEIR PREFERENCES?

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# TAKEAWAYS ON CARE PREFERENCES

1. Patients who had selected more intensive treatment are more likely to revise their care preferences.

2. Patients who died in the hospital are more likely to revise their care preferences.

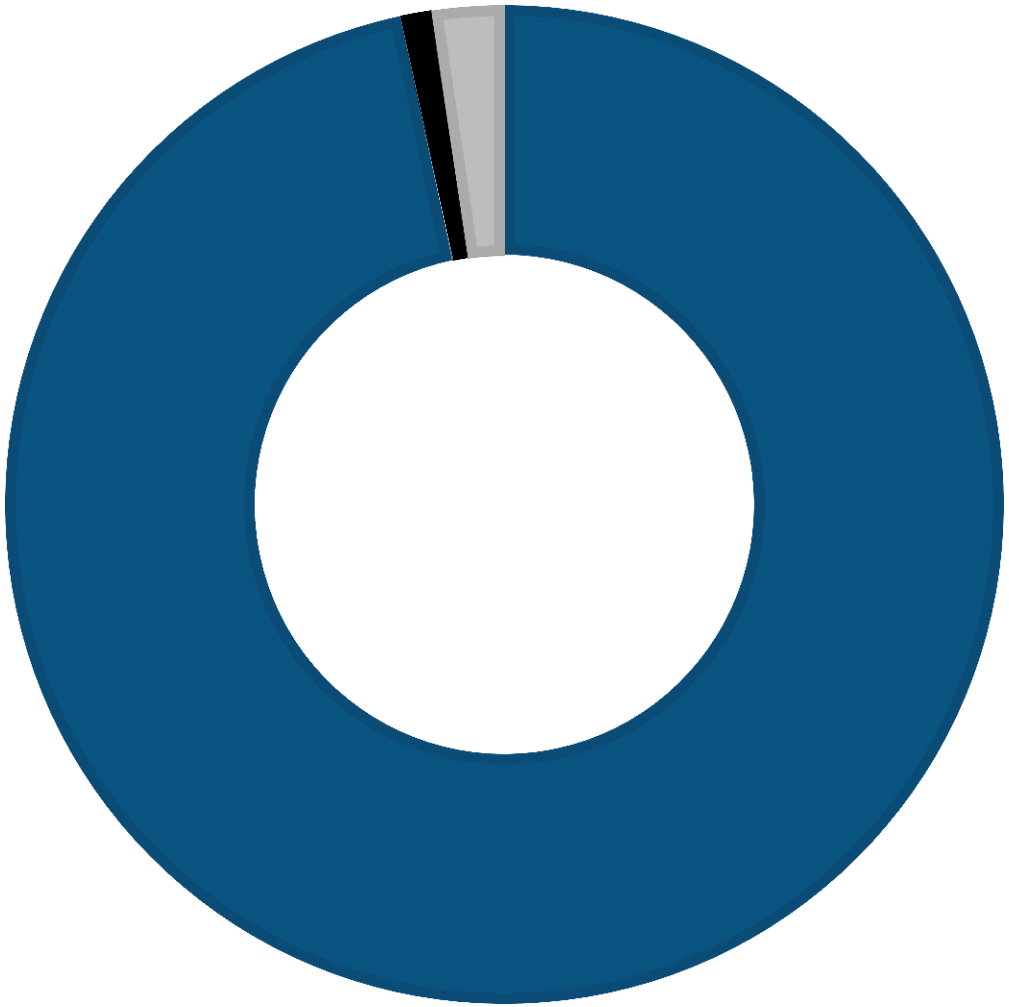
3. When patients revised their preferences, they generally selected less intensive care.

4. Patients who revised their care preferences generally did not use an advance care planning document (POLST, Advance Directive) to do so.

# FINDINGS

## Care concordance

# 99% OF CARE WAS CONCORDANT



- Concordant (290 patients)
- Discordant (3 patients)
- Unable to determine care received (7 patients)

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# DISCORDANT CASE #1: 93-YEAR-OLD WOMAN

| POLST selections | Agent present? | Setting of death |
|---|---|---|
| DNR<br>Comfort care | No | Hospital |

## Details of concordance evaluation

- Patient arrived after being found lethargic by assisted living staff. She received full, aggressive work-up for sepsis in the ED, orders written to transfer to ICU
- Pt's Agent (son) and alternate Agent (daughter) were both unavailable
- May have been confusion about patient's previous full code order for surgery the last time she was hospitalized

# DISCORDANT CASE #2: 92-YEAR-OLD MAN

| POLST selections | Agent present? | Setting of death |
|---|---|---|
| DNR<br>Selective care | Yes | Outside hospital |

Details of concordance evaluation

- Discordant care occurred in a SNF
- Patient died inside the hospital after SNF staff called ambulance and CPR was initiated; they had found him unresponsive in his chair after dinner
- Agent was upset by SNF's decision (as evidenced by documentation of a telephone encounter)

# DISCORDANT CASE #3: 79-YEAR-OLD WOMAN

| POLST selections | Agent present? | Setting of death |
|---|---|---|
| DNR<br>Comfort care | Yes | Hospital |

Details of concordance evaluation

- Discordant care occurred in a dialysis clinic; patient arrested while being dialyzed
- Patient received CPR and was sent to ED via ambulance
- Agent was unavailable

# TAKEAWAYS & IMPLICATIONS

1. Some specific situations may contribute to discordance, such as:
   - DNR patients who opt for a different code status than is on their POLST form
   - DNR patients who arrest in a dialysis clinic
   - DNR patients who arrest in the SNF setting
   - Patients whose health care agent is not immediately available
2. 20% of patients' care preferences evolved over time.
3. Manual chart review is the single best way to determine concordance. It is the only way to capture the final, verbal goals of care conversations often found in physicians' or clinicians' progress notes.

# QUESTIONS?

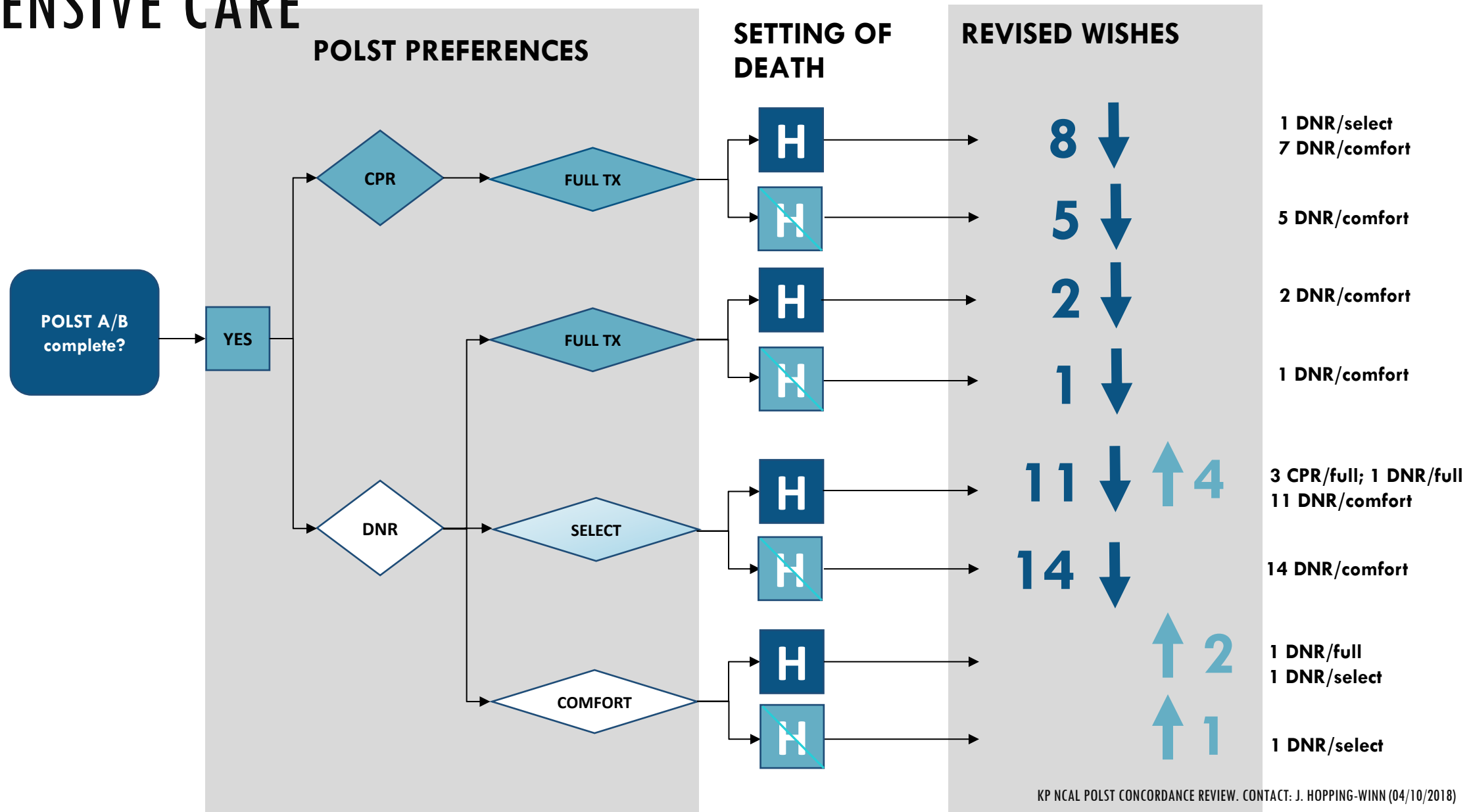
# APPENDIX

Supplemental Material

# CHART REVIEW METHODOLOGY: THE QUESTIONNAIRE

| Questions | | | Answer choices |
|---|---|---|---|
| **1. Did the patient have a POLST accompanied with a Life Care Planning Advanced Steps conversation?** | | | 1. No<br>2. Yes |
| **If yes to (1):** | a. What was the POLST preference for Section A? | | 1. CPR<br>2. DNR |
| | b. What was the POLST preference for Section B? | | 1. Full treatment<br>2. Selective treatment<br>3. Comfort care |
| | d. Was agent present for the LCP conversation? | | 1. No<br>2. Yes |
| | c. Did the care preferences change after the last POLST filed during an LCP conversation? | | 1. No<br>2. Yes |
| | If yes to (1,c) | i. How was the preference changed? (Please base your answer on the patient's final care preferences.) | 1. New POLST<br>2. New advance directive<br>3. Changed verbally by patient<br>4. Changed by agent<br>5. Changed by family (not agent)<br>6. Other |
| | | ii. What was the new Section A preference? | 1. CPR<br>2. DNR |
| | | iii. What was the new Section B preference? | 1. Full treatment<br>2. Selective treatment<br>3. Comfort care |
| | e. Was the patient enrolled in hospice care at the time of death? | | 1. No<br>2. Yes |
| | 3. Did the patient receive CPR? | | 1. No<br>2. Yes<br>3. Unknown |

# 85% OF PREFERENCE REVISIONS OPTED FOR LESS INTENSIVE CARE

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