ACTION ITEMS FOR OBSTACLES TO IMPLEMENTATION SUBCOMMITTEE

I. Policies and Procedures

Developing a Model Policy

It is our opinion that a model policy or set of procedures needs to be developed for health care organizations, to achieve systematic improvement in end of life care. Lack of detailed guidance can cause uncertainty, inaction, and consequently serious shortfalls in care. In framing this model policy, the Council should invoke medical management principles for accountability and the provision of quality care. A properly conceived and drafted model can capture best practices on how to identify key decision points, what kinds of questions should be asked, and how clinical data should be gathered and used. We stress, however, that this policy must maintain enough flexibility to respect a patient's individuality and a particular physician's clinical judgement.

II. Documentation

Continuity of Care

Burdensome paperwork, compiled again and again as a patient moves from one health care setting to another, is an obstacle to quality care that respects a patient's or proxy's wishes. We believe that lessening the burden of redundant paperwork will lead to fewer misunderstandings among health care providers and consistent adherence to an appropriate plan of care.

Specifically, the Council should consider the Physician's Order for Life Sustaining Treatment (POLST) form. This form is typically a one-page, two-sided document that is designed to help health care providers respect the end of life treatment wishes of patients or their proxies. POLST is a easily recognized physician order that travels with the patient and is honored by key health care providers and facilities. It thus achieves continuity of care across settings. POLST originated in Oregon and has been widely used there, with documented success. Variations are now used in other states, including Georgia, West Virginia, and New Mexico.

The Council should also assess whether the new (to be implemented on July 1 of this year) EMS/DNR order form is satisfactory and an improvement over the overly complex and unwieldy form previously required.

Maryland Hospice Network Survey

This subcommittee expresses concern whether excessive documentation is required for hospice enrollment. In order to gauge the true extent of this problem, the Council should request the Maryland Hospice Network to conduct a survey of their membership. This survey will shed light on the procedural hurdles that must be overcome before a patient can receive hospice care. We hope these data will be sufficient to allow the Council to determine next steps.

Certification

Ideally, the physician certification of a patient's condition, which the Health Care Decisions Act requires prior to surrogate decision making about end-of-life interventions, should be not merely a rote formality but instead a means to foster communication with the surrogate. In developing a model set of procedures, the Council should address effective communication of the information embodied in the certification. In addition, the Council should offer guidelines to surrogates on how to proceed when honest differences exist among physicians regarding a patient's condition. The Council should also explore the development of a standard, simplified certification form for physicians to complete.

III. Identification of Patients in Need of End of Life Care

Case Management Approach

The financing of hospice and palliative care services is challenging in part because Medicare and Medicaid as well as some private insurers force physicians and patients to confront the "terrible choice," that is whether to forgo curative treatments to gain hospice coverage.

In view of this situation, the Council should explore whether greater flexibility might be achieved through insurers' case management approaches, with the goal of enabling patients to receive cost-effective palliative care services even though they may not yet qualify for hospice benefits under their insurance policies.

Predictive Technologies

Additionally, we recommend that the Council identify non-proprietary modeling technologies that allow physicians to better predict which patients will need end of life care. We acknowledge that the predictive value of any technology to determine length of life is approximate at best, but it may help in providing some patients with a greater incentive for advance care planning and potentially better care.

✳ ✳ ✳ ✳ ✳ ✳ ✳ ✳ ✳ ✳ ✳ ✳ ✳ ✳ ✳ ✳ ✳