

decision-making in geriatrics

the new jersey polst form

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NOTE: This handout is in addition to what will be presented in class. Dr. Barile's powerpoint will be posted on the HCANJ website post presentation.

outline

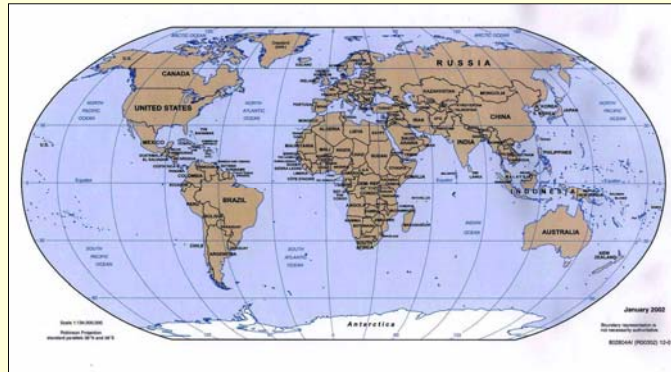
aging worldwide

“modern” medical decision making

new jersey goals of care

new jersey polst form

worldwide:



71

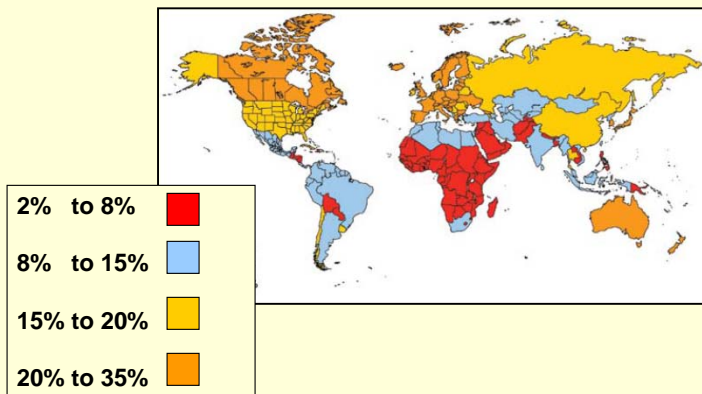
69

69

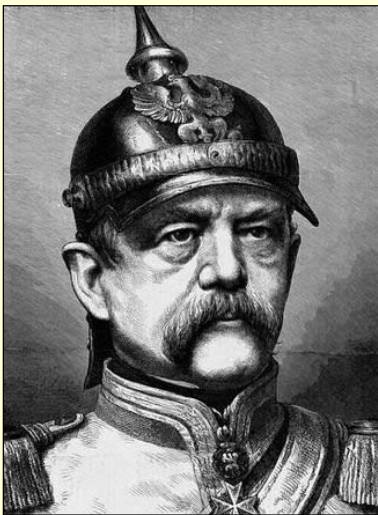
65

worldwide: trends

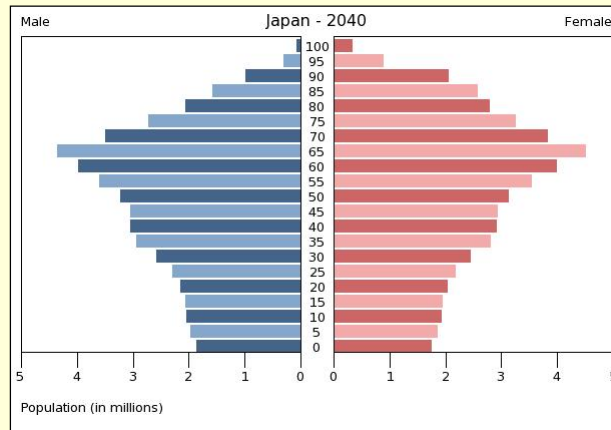
2030: % 65+



worldwide: germany



worldwide: japan



worldwide: russia

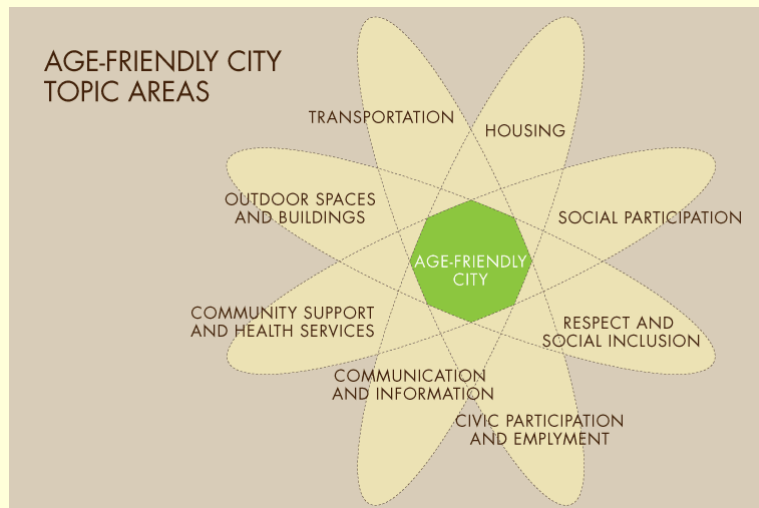
September 12th

June 12th

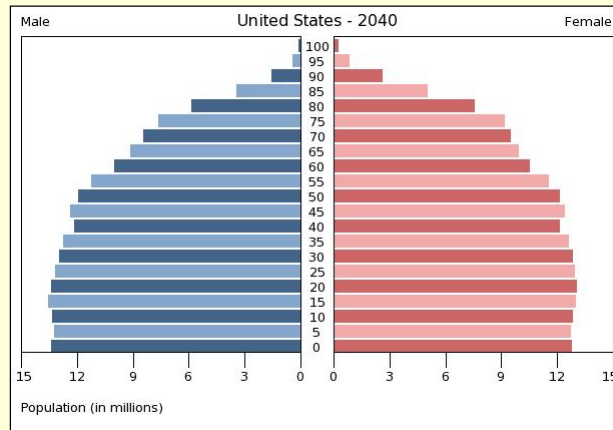
worldwide: russia



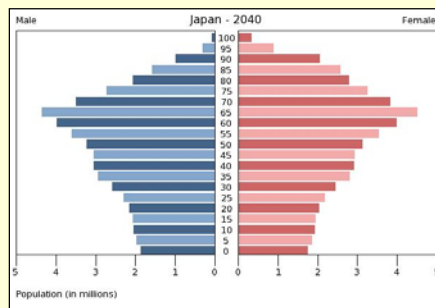
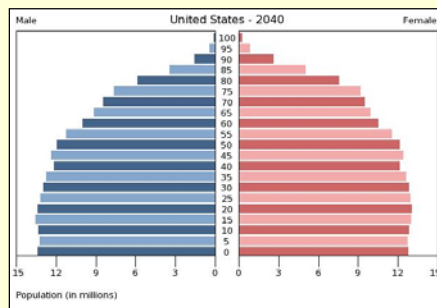
worldwide: WHO



united states:



united states:



big questions: worldwide

how will global aging affect:

- healthcare
- social security
- immigration
- trade and manufacturing
- finance
- defense

big questions: united states

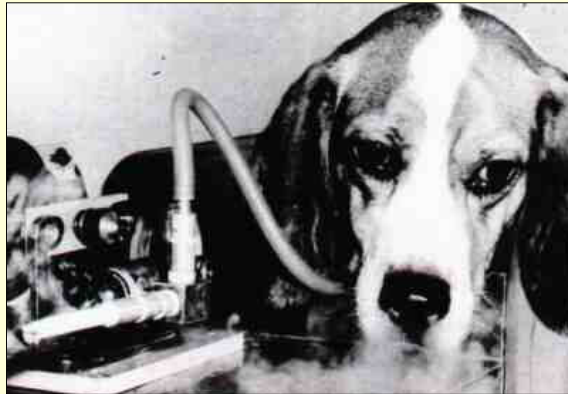
are our health care systems prepared?

- medical education
- residency training
- hospital systems

is our “modern” decision-making adequate?

“modern” decision making

1953



.....a dog named “knowsy”

“modern” decision making

pre-knowsy

1953

post-knowsy

shorter life
palliation

longer life
cure

holistic

body systems
body organs

“modern” decision making

2008

ACGME approved a **new** subspecialty in....
hospice and palliative medicine

subspecialty of ***ten primary specialties***:

internal medicine	family medicine
pediatrics	general surgery
anesthesiology	emergency medicine
radiology	psychiatry
PM&R	neurology

“modern” decision making

five barriers to quality decision making:

1. wrong financial incentives
2. inaccurately estimating prognosis
3. ageism and stereotyping
4. not addressing advance directives
5. not addressing ***goals of care***

“modern” decision making

1. financial incentives



“modern” decision making

2. estimating prognosis

age	total	male	female
Birth	78	75	80
50	31	29	33
70	15	14	16
80	9	8	10
90	5	4	5
100	3	2	3

“modern” decision making

3. ageism and stereotyping

“pleasantly demented”

“that gomer in room 805”

“he looks great for 92”



“modern” decision making

4. advance directives

not many people have them

not many doctors ask for them

not many lawyers know how to write them

“modern” decision making

4. advance directives

patient is always the primary decision maker!

if patient does not have capacity:

- step 1. advance directive
- step 2. substituted judgment

“modern” decision making

4. advance directives

“doctor, what would
you do if it were
your mother?”

“modern” decision making



“modern” decision making



“modern” decision making

5. not addressing goals of care

problem-based

heart failure
pneumonia
acute kidney injury
liver failure
sepsis
delirium

vs.

goal-based care

independence
reading
peaceful death
longevity
quality/function
specific tasks/events

“modern” decision making

5. not addressing goals of care

.....*simply ask:*

“what are your hopes for the future?”

the problem with new jersey



elliott fisher

jack wennberg

the problem with new jersey

last 6 months of life

	<u>USA</u>	<u>UT</u>	<u>NJ</u>
MD visits	29	17	41
hospital days	12	7	15
ICU days	3.2	2.2	4.6
% hospice	27	37	23
Inpt/Medicare A	14K	11K	22K
Inpt/Medicare B	4.2K	3.0K	6.0K

Dartmouth Atlas of Health Care 2008

the problem with new jersey

why?.....

not enough primary care?
too many hospital beds?
cost of living?
defensive medicine?
no residential hospices
inadequate geriatric curricula
few geriatricians

new jersey goals of care

mission:

.....to educate and support physicians and
health care teams
to ensure the specific treatment decisions
stem from and focus on the
patient's goals of care,
thus empowering the
patient and improving the quality of care

new jersey goals of care

academic

curriculum
medical schools
residency programs
schools for public health

public

goal based advance directives
website resources
minority populations
across cultures

government

residential hospices
loan forgiveness
polst form

physicians/hospitals

certification
tools for physicians
tools for hospitals
geriatric grand rounds

new jersey goals of care

90 year old healthy male admitted from the community with a stroke and unable to swallow or ambulate without maximum assistance.

swallow therapist recommend feeding tube.

what are the goals?

listening to music

treatment:

tube placement

new jersey goals of care

88 year old healthy female admitted from the community with a stroke and unable to swallow or ambulate without maximum assistance.

swallow therapist recommend feeding tube.

what are the goals?

return to gardening

treatment:

hospice referral

new jersey goals of care

four steps for good decision-making:

1. what is the diagnosis
2. what is the prognosis/best outcome
3. what are the goals
4. help achieve goals

right treatment
coordination of care
communication
future planning

new jersey goals of care

<u>present model</u>	→	<u>goals of care</u>
1. diagnose		1. diagnose
2. treat		2. prognosis
		3. goals of care
		4. treat

4. treat

new jersey goals of care:POLST

Physician Orders for Life-Sustaining Therapies

The map, titled "National POLST Paradigm Programs", displays the status of these programs across the United States. The legend indicates three categories: Endorsed Programs (dark pink), Developing Programs (light pink), and No Program (Contacts) (white). Endorsed programs are found in states including Washington, Oregon, California, Nevada, Idaho, Montana, Wyoming, Utah, Arizona, New Mexico, Texas, Oklahoma, Kansas, Nebraska, South Dakota, North Dakota, Minnesota, Iowa, Missouri, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina, Virginia, West Virginia, Maryland, Delaware, Pennsylvania, New York, Connecticut, Rhode Island, Massachusetts, Vermont, New Hampshire, Maine, New Jersey, and Alaska. Developing programs are shown in states such as Montana, Wyoming, Utah, Arizona, New Mexico, Texas, Oklahoma, Kansas, Nebraska, South Dakota, North Dakota, Minnesota, Iowa, Missouri, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina, Virginia, West Virginia, Maryland, Delaware, Pennsylvania, New York, Connecticut, Rhode Island, Massachusetts, Vermont, New Hampshire, and Maine. No program is currently in contact with states including Montana, Wyoming, Utah, Arizona, New Mexico, Texas, Oklahoma, Kansas, Nebraska, South Dakota, North Dakota, Minnesota, Iowa, Missouri, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina, Virginia, West Virginia, Maryland, Delaware, Pennsylvania, New York, Connecticut, Rhode Island, Massachusetts, Vermont, New Hampshire, and Maine.

National POLST Paradigm Programs

Legend:

- Endorsed Programs
- Developing Programs
- No Program (Contacts)

new jersey goals of care:POLST

POLST, what is it?

- actionable medical orders
- represent previous discussions on EOL care
- complement to advance directives
- brightly colored format
- portable across healthcare settings

new jersey goals of care:POLST

NJ: Out of Hospital DNR

- state-wide protocol developed in 1997
- honored by EMS statewide
- should be*** utilized when discharging
a patient with DNR

new jersey goals of care:POLST

How is POLST different from OOH DNR?

OOH DNR: not portable (only applicable to EMS)

POLST: addresses code status, *plus...*
travels across all settings

new jersey goals of care:POLST

core elements of POLST:

should be reviewed and renewed when:

- preferences change

- health status changes

- patient is transferred to another setting

- recommended for patients entering final years

new jersey goals of care:POLST

POLST timeline in NJ:

senate bill submitted/July 2010

senate and assembly health committees/2011

gov Christie

NJHA task force

NJHA will house POLST