Please stand by for real-time captions.

>> Welcome and good afternoon and thank you all for joining us today for the Nebraska emergency treatment orders Webinar. My name is Tammy Baumann with Great Plains quality innovation Network and I'm one of the Quality Improvement advisors in Nebraska. Great Plains is the QIN/QIO for Kansas North Dakota in Nebraska and South Dakota. Our aims to achieve better healthcare improved health, safer and lower healthcare costs. I would like to welcome and thank our audience for your participation today. Today's Webinar will be recorded and posted to our website www.GreatPlains QINPlainsQIN.org please note it will take about a week to access the recording and because of some snow in Virginia, we will have audio for the recording only. There will be an opportunity for questions after today's presentation or you can post any questions via the chat function on the bottom right of the screen. Paula Sitzman will be managing the chart feature throughout today's WebEx session are Great Plains QIN/QIO Care Coordination team works on forming community coalition throughout the Region to unite providers stakeholders and consumers in reducing avoidable Hospital admissions and medical harms. You can always keep up-to-date by joining a Learning and Action Network on the Great Plains website. Our website is full of tools and resources and the land is a wonderful opportunity to stay up to date and connected. Great Plains QIN/QIO now has social media presence you can liken followers on Facebook at Great Plains quality innovation Network or Twitter Great Plains QIN at great planes QIN. Now I'd like to introduce our speaker Doctor Lou Lukas Dr. Lukas is an alumni of UNC College of medicine Board certified in family medicine and hospice and palliative medicine and graduate of the Robert Johnson clinical scholars program at the University of Michigan. She's designed and lunch programs for seriously ill people in Pennsylvania, Maryland, and Nebraska including being the driving force behind the Nebraska Emergency Treatment Orders. Or neato. She's really a Medical Director for palliative care at Methodist Health System in Omaha. We thank Dr. Lukas for taking the time to present today and for sharing her knowledge and expertise with us. I am now going to turn the presentation over to Dr. Lukas.

>> Tammy thank you very much for your invitation to work with this group because I think it's a great opportunity to foster improved quality of care through improved continuity of care. Thank you very much for inviting me and thanks everybody who called in I appreciate your attention I think it will be a great opportunity for us to work together to think about how we take better care of the people in the state and I heard that there are people from the veterans home who might be on the line and currently as of this moment I met Methodist in Nebraska in Omaha but I'm actually moving to the VA next month. So I look for to working with you guys more closely too. I'm going to see if I have the right button, so the title of this practical strategies for Advance Care Planning introducing neato and what you see is also logo we developed called speak for yourself which is a patient facing campaign to really get across the idea that the best thing a person can do for themselves and their family is use their own voice and speak for themselves and think about what they want in case of emergency happens. And for those of us in Nebraska we are familiar with planning for emergencies like tornadoes and blizzards and things and just as we know that we are supposed to put candles in spare food and water in our basement for during tornado season we should also be thinking about what would I want if something happened to me that made me unable to participate in my medical decision, what would happen to me if I got hit by a bus if I had a sudden stroke, if something happens in this presentation will kind of take us through a new tool called NETO which stands for Nebraska Emergency Treatment Orders. I seem to be a little delayed when I'm pushing my page down button so let me see if I can use this button instead. So in Quality Improvement I think sometimes we think that our job is to prevent train wrecks how many times do we sit at an event that's happened and we think how did this train jumped the tracks, how did we get so far from where we were trying to go you can even tell in this picture it looks like maybe there was a bridge here once it looks like there was a train that was trying to get lumber and there's people scratching their chins going all my what happened here. I think our goal is to avoid train wrecks as much as possible. Train wrecks in our business look a lot different than this. Train wrecks for us look a little bit more and I'm having difficulty dashing look a little bit more like this. And those of you who work in hospitals are altogether too familiar with this. A situation where we have a patient who is really sick and dying ventilator and dialysis and a whole bunch of other things hanging from that IV pole and is one of those mixed blessings this is a fabulous place to be if you're the person who got hit by the bus and you absolutely needed everything that medicine has available to us because we could do lots of things to save people's lives. This is not such a good place if you were the very happy 92-year-old woman who is just waiting for God to take her to be with her husband but she didn't write that down anyplace and so when her grandchildren found her on the floor they rushed her to the Hospital and now she's on a ventilator and people are going now what do we do? It doesn't look like a very good idea and look like something she wants and so she is getting treatment that she didn't necessarily want and in the meantime if you're those of us who are involved in some more quality things, it triggered all the things we are not looking for and the specific example I gave you is one that I had on my service where we had a patient come in who did not have a palliative medicine consult or her previous hospitalization but she came in for what looked like a small intracranial hemorrhage but she was fine when she left and she made it very clear to everybody that if it had been where she did not want anything fancy. Didn't want to be resuscitated or be on a ventilator but that information just kind of got swallowed up the chart and she was transferred back to her home because things are going quite well for her, lo and behold 23 days later she was in the emergency room attended while immediately intubated and sent up to the ICU even before her family got there and of course as soon as her family got there they said grandma never wanted this she just told us she didn't want to be intubated she didn't want to be on the ICU if anything happened she didn't she wanted to be allowed to pass gently in her family had look at her and said my job is to take this away and it was such a burden for them because maybe we gave her a few more days maybe this or maybe if that and suffer through making that decision even though they knew perfectly certain that that is what she wanted. So the reason this idea came about this Nebraska Emergency Treatment Orders is to help us do a better job of addressing that situation. So again people who are familiar with quality know that what's important is we get to a root cause, how do we get here and how do we get to this place where we had a woman who is really clear about what she wanted and she was pretty -- at her age and what she had it was pretty predictable that something bad was going to happen in the not that distant future and nobody knew it would be that exacting or that exact time but how did we get in this place where we routinely do this with patients? So it's important I think to step back and really look at what other root causes and what are some of the historical precedents so I'm sorry the next couple slides are a little on the dry and legalistic side but I think it is important for us to go through and review some of the history that God is here because in my work as a palliative doctor I am amazed at how and also in my work in helping to develop this amazed at how little we understand about the laws and regulations in history that got us to where we are. So I'm having a hard time driving -- the basis for what we now call Advance Care Planning stems from the notion of patient autonomy and even I found that was misunderstood as we got through it. There's something in US law called common law and that is the law that is produced every single day when judges hear cases and make determinations and those determinations are then used as a president for the next case that comes up. So in the case goes to court the judge doesn't just sit there and say doesn't put a finger in the wind and say my mood today is this, they go back and they look to the history of what has happened in the courts. This idea of the Right to Refuse Treatment is firmly entrenched in US law not from the Patient Self-Determination Act but a lot of us are familiar with it dates back to the first case was heard in 1891 over 100 years ago, in a further case it was well spelled out in 1914 and every human being of adult years in sound mind has a right to determine what shall be done with his own body and a surgeon who performs an operation without his patient's consent commits an assault and that idea right there that we can't touch patient unless they give us permission is the basis for everybody's Right to Refuse Treatment from that period forward. So when people point to things like our Living Wills, that is kind of it those laws informant but the lawn is much deeper and much older and much more consistently uphold that she upheld in America there's a couple of exceptions all competent adults can refuse treatment even if it appears unwise or foolish so we can say this would be easy to fix and the patient can say no I don't want you to fix it and we don't have any right to contest that unless the patient is pregnant or B appears to clearly lack capacity and usually that's a very high standard to meet you have to go a long way to say to the person lost capacity emergency exceptions to obtaining consent of a person presents unconscious we assume that they have given us consent and the paradox between those two that one hand we assume that patient lung treatment but on the other hand the right of the right to refuse it somewhat causes a problem we experience I will let everybody know parallel rights demand treatment and so we know there's most clearly patients who can't pay don't often don't get treatment and a passion can't say I want you to treat me and we all know that there's patients would like treatment but can't have it for one reason or another or the treatment might not be appropriate so if I sell out my appendix out the doctor can say you don't have appendicitis on not taking your appendix up and so patient does have right to demand treatment. Now we move to the history of the law and the history of how we got the situational laws on the books but they were needed very often because up until the early 60s we didn't have anything that could actually keep people alive longer than they wanted. We were lucky enough to have treatment that did what we wanted to do let alone keeping people alive in situations whether body would not normally allow that. So we get the history that starts with CPR in 1957 it was started with the intention of treating unexpected sudden cardiac arrest such as drowning electrocution in arrhythmias and the goal is to maintain circulation while the underlying cause was reversed. It was popularized by the Red Cross in the 60s and spread over the country in terms of basic support and community settings it was given training to lifeguards and babysitters and in the late 60s it became introduced in the hospitals because emergency physicians and anesthesiologist thought it was a really interesting idea so you can see where it moves from a more lace Eddie where accidents are tending happen and really bad things are not common and when somebody drops suddenly it is more likely to be from a reversible event as opposed to when you move it to a Hospital where we clustered all the sick people so your pretest probability for having that condition you cannot recover from is much higher if you're in a Hospital so the lines are blurred when it starts coming into the Hospital. And because the outcomes were so different at that point if you're out at the pool in the 15-year-old falls into the pool the odds of resuscitating them are actually pretty good. If you come into the Hospital where the average person in here for CHS or COPD or some kind of malignancy the odds are not that good at all and so in 1974 the American Heart Association makes a formal recommendation saying that physicians should recommend DNR status to patients who have a likelihood of success and I don't think that that edict got carried out very well because we are a little resistant sometimes to think about it we think about the patient has the right to choose CPR and that's a whole other history in and of itself but actually the role of the physician is actually to tell patients when they're a bad candidate for it and that was affirmed by the American Heart Association a long time ago. So a legal history continues we continue to see problems with what happens we try to give people more treatment than they wanted and their more specific laws that went into effect started in the 70s and the 80s and then spread across the country Nebraska was one of the last states to adopt the lot and they adopted there is a 1991 so the first set of laws were about advanced directives. These were supposed to take the form of a statement that a patient would make to withhold or withdraw treatment. Then as it became that I had a patchwork of laws across all the states and another law was adopted in 1991 which was a federal lot which required that all institutions as patients upon admission if they have advanced directive and to provide information to them if they wanted and it made a lot of requirements for us in terms of making sure that every healthcare institution that received any money from the government has to accept an advanced directive where obligated to accept them and obligated to act upon them and we are obligated to provide information about them and we are not allowed to discriminate against people who have them. And based on that lot the joint commission implemented lots of things in policy this is institutions are required to have a policy about resuscitation status and about handling advanced directives. So what we learned is that these policies vary widely be tween institutions and some institutions lean toward what we think of doing what's best for patients and they said to have policies that say we recommend a certain form of advanced directives or we recommend for or against treatments that we think might be harmful and others lean toward autonomy and they say well the obligation is on the patient and the obligation is a patient should be making these choices but just be aware that just because you guys have a policy, your policy might not look very much like the policies that the institutions -- if we move forward this despite the fact we went through years of this and some folks are old enough remember these cases of care and Karen Quinlan Nancy Cruzan Terry Shyla all of those gave us the examples of these people who are getting futile care that we believe the patient didn't want. But all the work that went into it basically doesn't work. I know you can't talk back to me at the moment but just inside how many of you have seen a living will and power of attorneys that are regularly doing exactly what they wanted? Not so often. More frequently we get these piece of paper that don't say very much even though there quite long they don't give us the answers we need in the timeframe that's useful to us. So we think why are they not working so well why digging deeper was a real root cause of our problem. The first part is powers of attorney are rarely prepared to make the kinds of decisions they are and even when they are well-prepared it is extraordinarily difficult for someone who has an emotional attachment to a patient to quote make a decision or carry out the patient's own decision if it means that patient is going to die. It puts a level of burden and responsibility on them that is just an emotional human being that we are social being we are it is hard for people to do that so even the best prepared best informed people have a hard time doing this. Lots of times you don't have well-prepared folks so they don't know the decision was there afraid of annoying family members and might've actually motivations that are against what the patient wanted and might want to -- be there but kept alive so they can keep benefits of that patient and maybe not have a place to live and we have a whole host of reasons why turning to another person to make the decision doesn't work out so well for the patient in many cases. So why are we asking somebody else to make the decision? The reason is because a living will is either absent or poorly written and in truth there seems to be a problem it as a very format of the living will document. One of the reasons they are written by lawyers and not doctors so they say lots of things that sound legally appropriate but when it comes time to making a decision it just doesn't provide the answers that you wanted to. The documents are nonstandard in form and in content so you don't know where to look to get the information that you want. As directives are contingent on a phrase is as if I'm in a incurable or irreversible condition, which means by definition by the fact that those words are in there means you can't effectively refuse the initiation of emergency treatment. So if you have a document that includes that language and most of them in the state of Nebraska do, because there was a sample document that was included in our legislation, if you say that no emergency room doctors going to say I know for sure this is irreversible, they are not a physician they don't know the person before Hannah didn't have and know what happened and they said I can make a determination that dispersant is irreversibly held so I'm going to treat them and let the person downstream handle them and what we've learned is once that slingshot gets pulled back in the emergency room physician launches a patient onto a high level of care trajectory it is hard to change that trajectory once they left the Hospital. Or left the emergency room. In order to try to combat the situation that we have where the existing living will the powers of attorney didn't work very well, many states turned to something called pulsed pulsed physician order for life-sustaining treatment started in Oregon in 1985 and spread through about 35 states either have them in law or functionally sustained by professional endeavors. His stance for physicians order for life-sustaining treatment and there were several attempts of the Nebraska legislator to get that through and for whatever reason the legislature didn't asked that act upon it the most recent effort happened two years ago we put together new legislation to try to change some of Nebraska's laws and to adopt the Paul's PO Allstate and we didn't get the reception we were hoping for the Bar Association basically said we like the laws we haven't don't want them changed and the guidance they got this is a professional issue that the medical community should actually come up with a solution. You guys come up with a solution shall us it works and we will be happy to put into law for you. So we did. A group of us -- a group of us who were involved in that initial task force sat down and got a coalition of Accountable Care Organizations to say that they supported in Nebraska help Network took the leadership role keeping lots of other people in the mix but they're the ones who basically put the funding behind it to do the work it took to build something that would work within the existing consigns of the law of a state of Nebraska. So we made this thing called the Nebraska emergency treatment form and some ways it's informed by the pulsed paradigm and some will ways it varies substantially from assault to see specific interest in Nebraska in the way our laws are written. And at this point I realize I don't have a picture of it for you but at the end there is a link you can go and see all these documents. The NETO was a hybrid form it was a single page bright yellow form on one page it is a declaration which is another word for a living will is a legal term to describe a living will and the patient in that declaration said I give my consent to accept refuse or limit treatment there's a standardized set of things they are actually speaking to. On the other side of the form there's orders that a physician writes for EMS so the intention is it's a document that is written collaboratively between a medical professional and the patient and their family. It is standard in form and content so every form looks exactly the same and tell the patient makes their selections on them so if you're in emails person or if you are a physician or care provider in a facility or emergency department you know exactly where to look to get the information that you needed. It was not designed to be comprehensive but it was designed to track the most important decisions in a manner that makes sense in the order in which medical emergencies tend to present. And the only contingency that operationalize his the form is that the patient has a life-threatening condition and they lack the ability to make a decision for themselves. You guys can read the declaration for yourself later when the form itself is available. The form itself is designed to be available through medical providers because these we think the best decisions are made in collaboration with someone who can explain the implications of those forms and so that we could also make some statements about the state of the person who is making the declaration. We got some really good feedback from a legislature -- lawyers and judges and one of the most important things that the judges told us is that if I were -- there were to be a case and someone presented a form like this to me the thing I would want to know is that the patient knew what they were talking about and that they were competent at the time it was signed and of course the only way you can know that they are competent is heavy decision-making capacity is to have a medical professional say that in this form actually addresses a little bit of that. So what's available through medical providers, highly visible bright yellow paper, standardized orders for EMS signed by a physician on one side and a declaration signed and notarized for witness by the patient on the other side so one side gives direction to physicians and the other side is physicians giving directions to people who have supported like EMS providers nurses etc. Ideally these are crated in outpatient settings but quite frankly we are finding it most advantageous to work on the inpatient setting for our high utilizing patients and patients who have serious illnesses. It takes a lot more to ingratiate this into outpatient clinical settings but we are working on that as well. The form is designs to be created in the outpatient setting. It is owned by the patient and so it's adulteration just like a living will the document lines to the patient and it stays with them or if the patient is in the facility and stays on their chart and is transported by EMS. So it should go from place to place with the patient carried by the person who is transporting them. When you look specifically at the document it is comprised of four sections on the declaration side. The first one is how do we start treatment, what is the scope of treatment you want when an emergency initially happen before we know what maybe happened we know we found you on the floor but we might not know what actually caused you to fall on the floor. And there's three basic choices do you want everything you want to go to the ICU with everything we can do you want Limited or conservative medical treatment or you do want comfort measures and those are explained in more detail on the form and on the educational material that comes along with it. The next section is what are the indications that you would want to consider stopping treatment because in practice the most common thing that people will say when they make an advance care plan is that I want to try but not too hard, so the patient's if you simply are dealing with do you want treatment or not what treatment most people say well I think we should try but if you keep asking they'll say I want to try but I don't want to go crazy about I want to try a little bit and then there's reason people want to stop treatment and self we found the reasons that were most common for people so there's a notification that says no I don't actually want you to sit stop treatment want you to continue as long as there's medical indication to continue treatment in the next section says why would you want to stop and those reasons include the first one is because treatment is not working the second is because I have sustained significant brain damage the third is I'm not I might not be able to live independently, and the fourth is if my friends and family look at me and say that this person the benefits of the treatment do not meet the burden that are being caused by this treatment. So basically what you are saying is that the person is saying I understand but I want to stop treatment and here's some basic guidelines you can follow once treatment has started the third section is CPR status is simple yes or no and the fourth is long-term artificial feeding and studying this we found that in acute setting everyone who's eligible for medically administered hydration gets it but when the acute phase of treatment is over if the patient is still unable to speak for themselves what they want to be sustained with long-term artificial nutrition and hydration so that's the declaration side it does not answer every question but it answers the most important questions to give the structure of how medical treatment should follow and after those major decisions are made family history to make additional decisions in terms of how to augment the decision that the patients have made as a patient might even write additional directions if they thought there was something specific but in practice we have found that these address virtually everything that needs to be done to make sure that the treatment gets on the right track and stays there. Then that part of the form is signed by the patient and it can be witnessed by two people or can be notarized. And you turn the page over and the physician says an attestation that says I talk to this person, they understand what the choices they made on the other side are and I will write these orders for EMS to make sure that their wishes are carried out. And there's yes or no orders 41 CPR or does a person want CPR or not and should they be intubated or not and should they be transported from their current location or not. Those are orders that meet the standards for the protocols that emergency medical services in Nebraska operate under. We constructed this to provide the most direction for the medical team who would be receiving this to provide the most flexibility to accommodate every kind of treatment plan a patient might want and to protect everybody who is operating under this to make sure it is the highest standard of making sure that we know what the patient wanted acting accordingly if there should be disagreements about how that happens later. So what are the big questions of confusions is it is advanced directive or not and the question is both the pulsed who are familiar is kind of mushed together the patient's voice in the doctor's voice and what I look at I say it's kind of like my daddy said your daddy is strong enough to beat you up. Like my doctor says that I don't want this in written order for this. This form allows both the physician and the patient to have a voice so the first page is a declaration/living will it just looks different because it's in a standardized format. So if the patient already has a living will the needle replaces it just as a new advanced directive replaces the old one. We follow the most document that is been signed. Because it is an advanced directive it has all the rights and benefits of the Patient Self-Determination Act which means everyplace that receives government money for treating patients needs to accept it it is transportable and it can be honored at every facility. It also means that you don't need a host of new regulations or policies. You just need to recognize the form for what it is and if you already have a policy for an advanced directive, that is how you would handle NETO if it came at your institution. Now from a fine-tuning point of view you do need to do things slightly differently because it's a different form and people need to recognize it but from a global legal and policy point of view very few changes need to be made. But from a procedure point of view there's some fine-tuning and some need that sometimes the to be done and this is a question I get asked frequently that does a canopy away override it in the truth is no. From a legal point of view and then in court fairly recently with one of these cases where the power of attorney didn't want to do what the very clear wishes of the patient had written and the judge said of course not you must do what the patient's as I understand your well-intentioned family member but we have to do what the patient wanted. And so this is not specific to NETO but if you have a declaration that is actionable, then that declaration has higher legal standing than the power of attorney coming in and saying they want something different. Now from a legal point of view it's very clear how to enact that at the point of care in more challenging and requires a lot of training on the part of the providers who are present. So the needle even though it's one form in standardized that conveys the entire range of treatment from the most aggressive. You can say a person wants to go to the ICU and be on long-term life-support even if it means being ventilated at a facility postacute care they want to be full code and be maintained on artificial nutrition as long as necessary so the most aggressive possible plan or it can be a comfort only plant where the patient only wants to be kept comfortable and don't want any form of I support no CPR no artificial feeding and there are many options in between there and I think it's one of the things that is most powerful about is that it gives people the option to start but then to give very clear reasons for stopping and I have not seen a document yet that clearly and that puts it forward in a way that is operationalize about it is designed to be easy to redo it doesn't require going to an attorney it is done in the doctor's office within if you're doing it in a doctors office the patient signs it if they bring a family member or to both of those people can sign if the patient only brings one person that person can sign it and a member of the physician staff can be the second witness if you wanted to round up somebody in the waiting room you could do that if the patient were comfortable with that they may or may not be. But it requires two signatures or if the doctor's office has a notary available on their staff they can go ahead and sign that or go ahead and notarize it so it is designed as your help changes or family situation changes that you rewrite the document to match what your care has been because we find so frequently people go to the lawyer when they're 50 to get their wills done based on this is no living will that doesn't tell us anything dubbed vanilla living well when the patient was 50 years old now comes to the Hospital and there 75 or 80 with more serious illness and tells us nothing it doesn't help us in any way. We recommend that the patient's look at this at least one death once a decade at least anytime they get a new diagnosis or significant change in the current diagnosis or when they have significant changes in family relationships so for example people might be very motivated for aggressive treatment as long as their spouses a lot but once her spouse is gone they think I don't want to try quite as hard as I did as when my spouse was alive and those are the indications we encourage people to read the revisit the decision on the other hand we did not require that because the situation where you would inevitably find yourself is if we set we would require this form be re-endorsed every three years, well great so 37 month turnover in the patient shows up with the exact situation that they described in the emergency room. While the document is 37 months old is it stale and said it should be renewed at 36 months so rather than do that we make strong recommendations that people refresh it on a regular basis or when things change but that's in common on the patient themselves rather than on following up with the form. There's a form for making the form and what you do and there is a strategic deployment in this Webinar as part of its own 2017 was all about development and logistic pilots so in the Omaha area we been piloting this largely through the Methodist Health System but also through the Nebraska system in Bellevue University and the Fremont system we have a couple hundred of them out there and have EMS onboard they are working swimmingly we have patients who been readmitted in the Hospital says this make such a difference and so it's exactly what we were looking for. We had with the patient wanted at the time we needed it. The next step is to prepare our healthcare systems so really how do we spread this in a way that will work for everybody and because it has to be done jointly between healthcare provider in a patient we need a prepared healthcare system to work with patients and then finally we need to work with activating patients so in the interim phases we are making these available through healthcare providers we are not doing any kind of direct to patient advertisements or marketing because the healthcare system is not ready but as soon as the healthcare system is ready we can go ahead and continue with that. So the needle is the basis for a system of care. By itself it's just a piece of paper and so the system is made up of different parts in their planners and those are the patient and medical confessional guys and that can be done in many ways but is the activated patient who talks to their doctor about what their choices are and that group I find there's low hanging fruit which is people like my mom who says if something happens to me just shoot me and she knows exactly what she wants and she just wants to be kept comfortable and let go and she will go to her doctor and say this is what I want check check check those of easy once in the hard ones will be when you have the patient who really needs to think about it are having a harder time about it and that requires a higher level of sophistication of your healthcare providers. And certainly more than we can do in the context of a phone call. Then we have the plans a piece of paper that have the decisions on them and those are transferred to the performers and who performs of things that are involved in if EMS people who are in our emergency department it's our hospitalist or doctors who are seeing people in the Hospital and is the facilities to whom the patients are transferred postacute care or where they are living and so those are the people who constitute the system of care. So needles a basis of a community-based program a plan is no good by itself unless the community is involved so you really have to think about how do you design the system in your community and Nebraska is a state where the communities are tremendous and you can be a community without a local Hospital and everybody gets transferred someplace else. You can be in a community like Omaha where we have half a dozen different hospitals and they all are are part of that need to meet the regulations. Define the system as is exist in your community we have to get your EMS or first responders absolutely need to be involved in the hospitals we are affiliated with need to be aware of what is going on and have a plan to anticipate these forms coming in then you need a couple of doctors or nurse practitioners or physician assistants whenever the people are senior patient at the facility assume they will be transferred if you get that group of people around the table you can have some strategy meetings and say we need a way to help people maintain their voice and we think there's a tool we can use I think we could go about using it and it really doesn't take as much -- took us a long time to come up with all the legalese about making this form work for once he form was available we started showing it to people people really wanted it EMS was tickled pink to have something that would be this consistent because they are called in a situation all the time based on hard to manage and hospitalist were delighted they would love to know what the patient wanted when they came in so it doesn't want you can present something quick concretely to the committee people are pretty excited about the idea of making it work. So you start a small test of change with the collaborating community and then you will correct a couple errors along the way or change a process along the length and as people see it work there will be a natural division across a community of people who wanted in overtime will get to the point where we have in a providers onboard that will be able to go to the public with whatever makes sense in your community whereupon to speak for yourself campaign but anything networking your community would be appropriate for your community. We are looking for ways to think about how would we get started and all these various committees what do we need we have a starter set of materials that are available so we have the form as I described which includes the declaration in physician orders as he form that most people will have and there's also a set of standalone orders that is only the physician order in the reason for that is some people don't have capacity to make decisions and according to Nebraska law, at this point their loved one cannot make a declaration on their part. They can help craft the decision run the medical care but they cannot make a declaration and so I know it sounds a little goofy but it is the truth. That's one of the things we would ask the legislature to fix but in the meantime we don't have a fix for the there's just a standalone order so if you have a couple in one of them has dementia the wife says I know he doesn't want XY is a you could write in out of Hospital dinar and do not intubate order for that person but they cannot have the declaration part. A wallet card and you have patients more functional in the community there's a card that has a contains the three orders and says I have a needle form find it and descended to the person who would be at home to get it for them and there's a clinician education brochure that goes to through everything I went through with a little more detail and there is a really excellent patient planning form it's a four-page document that starts with where are you in your life here are four decisions you might want to think through and helps them think about what they might want in those situations based upon where they are in their lot and a sample form that they can do and say you can distribute these and people can bring them back and talk to their doctors about there is a trifold that can go in waiting rooms or public settings to gain some more attention to it there is an office poster that talks about a patient named Don and how he goes to the healthcare system and how it helps him out and there's a series of things called the truth about its truth about code status truth about resuscitation status the truth about life-sustaining treatments just because what people see the most is what's on television and that is so rarely accurate so that's why we called it the truth about series. It goes through some of the things that people may not understand about that. There's one video that you might get a link for or will be able to post a link for that we did for healthcare providers and we have three more videos in the making one is why should we think about planning a second and specifically how to work through the four questions and a third is how to introduce it to medical environments and physicians so they understand what they are doing on their part of the deal when they are signing the form. All of those with the exception of the videos are available now and there's a link on the page next. A professional website for the Nebraska health Network.com site and an agent has put these forms on their site so everything I just read off to you is available. You can download and use it there is no copyright the only thing you cannot do is change the form. The form we need to maintain continuity because when it becomes nonstandard we are in trouble the actual need a form and standalone orders themselves cannot be altered. But everyone is free to use them.

>> I have a couple more slides to go through detailed Bible is limitless we need to but I figure at this point it would be great for me to take a drink of water and it would be great to get whatever questions you guys might have.

>> Dr. Lukas I actually got kicked off WebEx. You move the slides if that's all right. We are going to take some questions now and thank Dr. Lukas for providing this excellent presentation and while people are preparing their questions, we like to see if there's any question submitted through chat. To ask a question of Dr. Lukas please push\*five. Or you can chat your questions and so Paula can you tell me if there is any questions in chat?

>> Yes we have one question do the forms come in Spanish?

>> Not yet. The question is do the forms come in Spanish? We have not made them in Spanish yet. The issue that we have and we need to wrestle with is that the forms it is possible that the forms are going to continue to be in English but the educational materials and translation of them would be available because the forms have to be assessable to the people who are receiving them. So EMS and emergency etc. need to be able to act on them so at this point we have not translated them but we intend to.

>> Thank you Dr. Lukas. Is there another question Paula in chat?

>> Yes another question comes from Shay Lynn -- are there any issues with utilizing needle form out of state?

>> The needle form would follow NETO form same guidelines covered by the Patient Self-Determination Act and remember that any time I healthcare professional knows what the patient wants, we are obligated to -- if a patient came in saying I do not want CPR and signed and dated it on the back of an envelope, they healthcare providers actually obligated to do that so there's not -- there's not the kind of obstacle to taking things from one state to another state. It's just that the forms tend to be more tailored to individual states. But because this meets the standard of an advanced directive, it is covered by the Patient Self-Determination Act and as such any place you would go to the Hospital is that any healthcare institution is obligated to accept it.

>> We have another question -- was the governor appointed palliative care committee involved or is this the fruit of that committee?

>> No. I'm not even certain that that committee has met yet they have may have had one meeting but that committee -- this group has been meeting for quite some time and that committee has recently been appointed and I am not certain the committee's focus that focused on this as much as it is on what constitutes good quality palliative care. Not even sure within their purview.

>> I want to check quick with Nikki to see if anyone is on the phone.

>> One question from [ Indiscernible] currently we use a POLST form and we are wondering how we transition from the peel Allstate to the NETO any suggestions?

>> I think you could just bash what community are you in?

>> Metro city.

>> I think because at this point there isn't any or nothing exclusive about either of those forms, I think you could just begin using the NETO making it available in the places that you currently utilize the POLST form and then when patients come back the doctor and says we have a new form would you like to utilize that so it is more consistent or the next time is time for them to think about renewing it just renewing it on the current form, I think the NETO offers a couple of advantages with because the NETO -- the POLST is a physician order a physician cannot order when the patient would want to stop treatment. So those forms don't have that option available and I think what makes a neato more powerful and I think it makes it more powerful but makes it more compatible with some of our more conservative members who are really worried about the right to life because you are not saying I'm not going to try, gives you the ability to try and and stop and is much more compatible with the more conservative people in our community than just a firm yes or no. So I think there's reason to think about it but I think you could just overlap them for a while and say over the course of time you would replace the existing form.

>> Thank you.

>> Nikki do we have another question? By phone?

>> No other questions on the line.

>> Paul I see there's a couple more questions in chat.

>> From Don in the past healthcare personnel were not allowed to witness advanced directive forms. Did I understand correctly that now as long as one of the witnesses were family etc., the other could be a nurse or nurse aide etc.?

>> Yes that's actually a misunderstanding in the line is because Nebraska has two different laws. One is the right to the terminally of which is where declarations and the declarations law says that a single representative from the healthcare facility can actually witness. The power of attorney law is very explicit in that I healthcare provider cannot witness the power of attorney but this is not a power of attorney document. And so at some point those two became conflated and people just said no healthcare providers can sign a form but if you go to the right for the terminally ill act is specifically says that one of the witnesses can be an employee of the healthcare institution and I think it's important that the doctor or nurse practitioner or physician assistant who is signing the orders not be a witness. But another person can be in that since statute.

>> This is from Chris -- in collaboration with palliative care when a patient is in the Hospital, can this be done as input -- as inpatient as well as in doctors offices? How are the education of the physicians going to take place?

>> Absolutely. The question is can we do it on the inpatient side and absolutely and we are finding that to be just a really bright area for doing it and at least half of the forms we haven't distribution in Oman now come from our palliative care inpatient or outpatient teams because we are having such detailed conversations with people and so the edge -- first answer is yes you can do setting where Medical Professional and a patient who have come to an agreement about what their choices are that form can be signed. The next question is how will doctors be trained? That is a whole other thing. I have several talks about how to train doctors and it ranges from what I currently call the low hanging fruit which is the minimum standard is the doctor has to understand the orders that they're signing and what it means to declare patient to have capacity which is actually very clear because patients are getting consent for -- doctors are getting consent from patients all the time so there is an assumption about capacity. That's the lowest level and you go to the people who need a little more conversation and you need the highest tier which I would tend to delegate to our friends and palliative care if you have those people available in your community where you have a resistant family or family who's having a hard time understanding the choices and what their medical situation is currently but the training to have those kinds of conversations is a little more challenging. On the other hand, the educational material that is on this website is really quite good and if you have a doctor who is inclined to do this kind of work or somebody who thinks it's important, it doesn't require much training. It require training to have the more sophisticated conversations.

>> Thank you, Dr. Lukas I think I saw one more or a couple of questions we have four minutes left in the presentation.

>> I like to say one thing quickly which is so right now and HN is holding the banner because they are the ones who helped so much in the creation of it and made their marketing people available to do all the drawings and forms but we are actually beginning entity which will be like a placeholder as this because through the diffusion phase and so I'll be looking for contact information from you all to talk about how we get regional representation, how we provide disseminate this more thoroughly but because my transition at this time we wanted to give this talk for you guys now and probably about a month that larger organization will be available we can kind of seek membership for and have a website up and have be more specific about training and community pieces. If we have time for one more question and I think actually the website for the new organization is going to be called Nebraska neato.org ill be up within a month.

>> All right Paula we have time for one more question and if we continue to have more questions I will off-line ask Dr. Lukas and we will post those on her website. So one more question.

>> How do EMS personnel access neato desk the needle form quickly -- neato form quickly EMS for patients who are frail we suggest that we put the neato if they're leaving a home on the refrigerator if they're in a facility that is on their chart or held by the bedside someplace for people who are not frail people that want to make their wishes explicit recommending family know where they are so you keep in the most likely place and you keep the wallet card in your wallet so EMS is aware of it.

>> We have one more question --

>> question two attendees if none of the content or order is changed is it acceptable to create an electronic version of the form to transcribe the information that is on the written form this would not replace the written form with signatures but be more readily available form that would be accessible within the EHR?

>> Very good question. The first answer is yes, what we do at Methodist is when the patient comes in it is scanned into our record and it goes into a specific place in the record so it triggers an alert in our banner so that every physician then in the system whether in an office or in the Hospital area or department someplace can find that neato quickly so that is a possibility and if it works within your EHR you could do that as well. You sure you have to deal with then is if you are or have a form a team an earlier and the patient comes in on a subsequent omission you need to have a process to ensure the patient still wants it. Our lawyers have pulled up is that the most recent information you have is what you should go with and so the patient has given you something you go with that information unless they've given you a second piece on top of that. But you need to make sure that your policies and procedures about assuring that or at least asking if there is any additional information are in place. One of the things the new entity would be looking at is that there are some states that I should have a registry function where instead of carrying a piece of paper you say I'm Lou Lukas 123 go look at my record and it would be an app or website or registry someplace but that's not available in Nebraska at this point. There are couple of states that are trying that idea.

>> Thank you, Dr. Lukas I want to say there's a couple of questions I think on the phone and I want those people to either send me an email so I can ask these questions of Dr. Lukas and get back to, if you have any questions you can email -- forward the slide -- you can email us with any questions you have. Here's our contact information we thank you for your participation today and hope you found the information valuable and applicable we want to thank Dr. Lukas for helping make this a successful event and we appreciate your time and participation Dr. Lukas and we want you to visit the Great Plains website at Great Plains Queen.org for read sources tools and Webinars at Great Plains QIN and join if you're not 1 million members so you can receive notification of future educational offering provided by Quinn and complete evaluation form for the today's event offer feedback and plan and coordinate future events like today and your input is important we want to be sure that we are meeting your needs in our educational offering so thank you again this concludes our presentation and have a great afternoon and again if you have questions please email either Paula or myself. We will get those answered. Have a great day.

>> [ Event Concluded ]