Nebraska Emergency Treatment Orders (NETO): A New Tool for Advance Care Planning
Great Plains QIN Support

Coordination of Care
Better patient outcomes, overall satisfaction and reducing avoidable hospital admissions

Effective Communication and Care Coordination
Nearly one in five Medicare consumers discharged from the hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 million every year.

Avoidable readmissions and patient satisfaction with discharge care are growing problems nationwide. Of those patients who are re-admitted to the hospital, the Medicare Payment Advisory Committee estimates that 64 percent received no post-acute care between discharge and readmission and project that 76 percent of readmissions may be preventable. Further, CMS research shows consumers report greater dissatisfaction in discharge-related care than any other aspect of care.

The problems associated with poor transitions of care and 30-day hospital readmissions are not solely the responsibility of...
How to Get Involved

Learning and Action Network

We invite you to join the Great Plains Learning and Action Network (LAN). All LAN partners will be invited to attend educational sessions on a variety of topics, have opportunities to learn from peers throughout the state and region and have access to an abundance of resources and tools. The LAN is a great opportunity to get connected and demonstrate your commitment to quality improvement. To sign-up, visit: greatplainsqin.org/lan-signup-page/
We Have Gone ‘Social’

- Like Us and Follow Us
- Be part of our conversation

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Our Speaker

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www.nebraskahealthnetwork.com/nebraska-emergency-treatment-order-neto/

Nebraska Emergency Treatment Orders (NETO)
The healthcare provider work group has developed this program to assist you in helping patients plan for medical emergencies. No changes may be made to the NETO form unless properly signed and witnessed as indicated in the Nebraska Patient's Rights Act. Settings.
Practical Strategies for Advance Care Planning: Introducing NETO

Lou Lukas, MD
Medical Director Palliative Medicine,
Nebraska Methodist Health System
Associate Clinical Professor, UNMC

NETO Nebraska Emergency Treatment Orders
Avoiding Train Wrecks

Nebraska Emergency Treatment Orders
You Never Think When It Starts, It’s Gonna End Like This...
“Honey, how’d we get here?”
History Lessons and Legal Context

• The Right to Refuse Treatment
  
  – *US Common Law 1891-present*
  
  – “Every human being of adult years and 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.” *Schloendorff v. Society of New York Hospital* 1914

• All competent adults may **refuse** treatment for any reason, even if it appears foolish or unwise.

• Emergency exception to obtaining consent
  
  – In the absence of other direction, emergency treatment may be provided without consent

• There is no parallel right to **demand** treatment
  
  – ~EMTAL requires appropriate triage
History of Life Sustaining Treatment

• CPR
  – Invented in 1957 for *unexpected, sudden* cardiac arrest
    • drowning, electrocution, arrhythmias
    • to maintain circulation while the underlying cause was reversed
  – Popularized by Red Cross in 1960’s for basic life saving in community, life guards, baby sitters, etc
  – Incorporated by ED and Anesthesia in hospitals (blurred the lines)
  – 1974 due to poor outcomes and increased morbidity, AHA advises *physicians* recommend DNR with consent of pt or surrogate for poor CPR candidates
Legal History Continued

• 1970’s-80’s Advanced Directive laws emerge in most states—
  – Advanced directives merely project the existing right to refuse treatment into the future when the patient lacks capacity

• 1991 Patient Self Determination Act requires institutions ask patients upon admission if they have an advanced directive and to provide information if they want it.
  – Advanced directives are voluntary, may not discriminate against people with advanced directives.

• Individual Institutional POLICY instructs DNR utilization.
  – TJC requires facilities to have a resuscitation policy
  – These policies vary wildly between institutions
  – Appears to be influenced by institutional cultures that prioritize either autonomy or beneficence
LET’S FACE IT, CURRENT ADVANCE CARE PLANNING DOESN'T WORK
But Why?

- Poorly prepared POAs are making decisions
- Because Living Wills are either either absent or poorly written
  - Written by lawyers, not doctors
  - Non-standard in form and content
  - Directives are contingent on “Incurable or irreversible condition,” which means you can’t effectively refuse the initiation of emergent treatment
  - Stopping treatment once started is like stopping a train that has left the station...
POLST

• Some states did “POLST Paradigm”
• Physician Orders for Life Sustaining Treatment
• Nebraska legislature didn’t act
• Told the professional organizations to develop a non-legislative, professionally based standard
• So we did- 6 ACO’s lead by Nebraska Health Network created a Nebraska process
Introducing the NETO Form

- Patient’s Declaration to consent, refuse or limit treatment, and
- Physician Orders for EMS.
- Written with medical guidance
- Standard in form and content
- Contingent only on life threatening condition and lack a decision making capacity
The NETO Form

- Obtained through medical providers
- Highly visible (bright yellow)
  - Standardized, 2 sided form
    - EMS Orders
    - Declaration of healthcare decisions
- Ideally, created in out-patient setting
- Transported by EMS
- Form stays with patient/on chart
Nebraska Orders for Emergency Treatment (NETO)

• Structured Declaration (aka Multiple Choice Living Will)
  A. How to start treatment (ICU, Gen Med, Comfort)
  B. When to stop treatment (Common reasons people withdraw treatment)
  C. CPR status (yes or no)
  D. Long term artificial feeding (yes or no)

• Out of Hospital Orders for EMS (Y/N)
  – CPR
  – Intubation
  – Transport

• Physician’s attestation of discussion and capacity to make decisions
NETO IS an Advance Directive

• It is a Declaration/Living Will, it just looks different because it is standardized.
• If someone already has a living will, NETO replaces it just as any new advanced directive replaces the old one.
• If has all the rights and benefits of the Patient Self Determination Act
  – Transportable
  – Honored at any facility
• Declarations have more legal weight than a POA’s opinion.
NETO: One Form, Many Plans

• One form conveys entire range of treatment
  – Most aggressive-
    • ICU, Long-term life support, Full Code, PEG
  – Least Aggressive
    • Comfort ONLY, no life support, no CPR, no artificial feeding
  – Everything in between

• Evolves over time- easy to rewrite
  – Each Decade
  – New Diagnosis
  – Changes in family relationships and responsibility
GREAT, THERE’S A FORM.
NOW WHAT?
Strategic Deployment

• 2017- Development and logistic pilot (NHN)
• 2018- Prepared Healthcare Systems
  – Diffusion to healthcare systems and providers
• 2019- Activated Patients
  – Significant Deployment Direct to Patients
NETO is the basis for a System of Care

- Systems are made up of different parts
  - Planners- patients, families and doctors
  - Plans- the decisions of the form itself
  - Performers- the people who enact the plan
    - EMS
    - Emergency Departments
    - Hospitalists
    - Facilities
Community Based Program

• Define a system in your community
  – The EMS providers
  – The hospital
  – Some doctors
  – Some facilities

• Strategy meetings
  – Gain consensus
  – Develop a training plan and goals
  – Start a small test of change
GET STARTED IN YOUR COMMUNITY!
Materials Available

• NETO form
• Stand Alone Orders
• Wallet Cards
• Clinician education- 4pg
• Patient planner- 4 page
• Office Brochure- trifold
• Office Poster
• “The truth about...” series
• Pending- 3 video’s “Why Plan?,” “How to Plan?,” “Doctor Intro”
Professional Website

• www.nebraskahealthnetwork.com/nebraska-emergency-treatment-order-neto/
A. Scope of Treatment

- If you ended up in the ED with a life threatening emergency and could make your own decisions, what would you want us to do to keep you alive?
  - I want everything (ICU and all that goes with it)
    - Most people, most of the time
  - I want limited, non-invasive treatments (General medical treatment: fluids, blood, medicines, noninvasive ventilation, minor procedures, etc)
    - Frail people who are not likely to do well with more invasive treatments
  - I want to comfort measures only (Don’t bother, just keep me comfortable and let me go)
    - A surprisingly high number of elders
B. Stopping Treatment

- What if the treatment isn't working or will leave you in a bad situation?
  - I want to stay on life support as until every rock has been turned over.
  - I would want you to stop life sustaining treatment if:
    - I get worse or don’t improve in a few days
    - I get worse or don’t improve before PEG and Trach
    - I am likely to have serious brain damage
    - I am not likely to be able to live at home
    - My friends and family think I would find my outcome unacceptable
C: Code Status:

- Attempt Resuscitation (CPR)
- Do NOT attempt Resuscitation (DNR)
  - FYI
  - On average, only 10% of the people coded survive without significant brain damage.
  - Odds vary
    - ~25% for young healthy people (who don’t often code)
    - <1% older, sicker people with multiple serious illnesses
  - A pleasantly demented 80 y/o from SNF with PNA and hypoxia has 3% odds of good survival.

Nebraska Emergency Treatment Orders
D: Long Term Artificial Nutrition and Hydration

- Everyone who can eat is fed. Short term nutrition and fluids part of acute treatment. This is about long term nutrition through a PEG tube if you still can’t make your own decisions.
  - Yes, I want a PEG tube and artificial feeding.
  - No, I don’t.
Signatures, Witnesses, Attestation

• This is a legal document
• It is the most consequential decision most people have to make
• It requires:
  – Patient signature
  – Two Witnesses or Notary
  – Physician Attestation
    • The patient understands the implications of the decisions
    • They were competent when they sign it
References

- **Schloendorff v. Society of New York Hospital** 1914
- **The Joint Commission Standards**
  - RI.01.05.01: “The hospital addresses patient decisions about care treatment and service at the end of life.”
    - “1: The hospital has policies on advanced directives, forego or withdrawing treatment, and resuscitative services in accordance with law and regulation.”
  - RI.01.02.01: “The hospital shall respect the patient’s right to participate in making decisions about his or her care, treatment, and services. Note:... This right is not to be construed as a mechanism to demand provision of treatment of services deemed medically unnecessary or inappropriate.”
    - “3: The hospital respects the right of the patient to refuse care, treatment or services in accordance with the law and regulation.
    - “5: If the patient is unable, the hospital respects the surrogate’s right to (the above)
- **Serious Illness Conversation Guide**
  - [https://www.ariadnelabs.org/areas-of-work/serious-illness-care/](https://www.ariadnelabs.org/areas-of-work/serious-illness-care/)
  - Communication about serious illness care goals: a review and synthesis of best practices
  - A Systematic Intervention To Improve Serious Illness Communication In Primary Care, Health Aff July 2017 vol. 36 no. 7 1258-1264
- **GOFAR: Good Outcomes Following Attempted Resuscitation,** Mark Ebell, *JAMA Internal Medicine* Sept 2013
Questions

Press *5 on your telephone if you have a question you would like to ask.
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