Advance Care Planning

Training for Participants of the Integrated Healthcare Association (IHA) Quality of Life Conversation 2013
Objectives

• Describe the key elements and related strategies in an effective advance care planning program.
• Describe the differences between an Advance Health Care Directive and the POLST form.
• Discuss the importance of advance care planning with employees.
• Demonstrate beginning competency in facilitating employee workshops on advance care planning.
Overview

• What is Advance Care Planning
• What is the role of Advance Directives
• How does POLST fit in
Why Plan

• 50% of people at the end of life
  • Won’t be able to make their own medical decisions
• When health professionals are uncertain
  • The default is to treat aggressively
• Family is left with
  • Uncertainty, Stress
A True Story

- Mr. B had severe lung disease after years of smoking. At age 72 he was unable to walk from his bedroom without stopping to “catch his breath.”
- He was hospitalized after spontaneous rupture of his lung and immediately placed on a ventilator.
- He had never appointed an agent, nor discussed his wishes about the end of life.
- After 8 days he was in severe distress and required multiple drugs to comfort him.
- His daughter—the only family in town—was left to make the decision to remove the ventilator and allow his death. He died a few hours later. He never got to say “goodbye” to his son or friends.
Advance Care Planning: The Problem

• No communication
  Family and community are in the dark about what the patient values, would want from a difficult situation, or would find unacceptable as an outcome.

• No documentation
  No Durable Power of Attorney for Health Care, no Living Will, etc.
ACP: A conversation about...

- What is **important** to the individual
  - Hopes, goals and concerns about the future
- The **realities** facing the individual
  - Diagnoses, abilities, limitations, resources
- **Completing** documents and arrangements
Advance Care Planning: Three Levels

- Level One – All Adults
  - Talk with family about wishes
  - Identify surrogate
  - Complete advance directive

- Level Two – Adults with Chronic Illness that increases chance of life-threatening events
  - Same as above, plus
  - Discuss role of POLST

- Level Three – Adults with relatively short expected life-span
  - Same as above, plus
  - Complete POLST
Advance Care Planning Process

Advance Care Planning Continuum

Age 18

Complete an Advance Directive

Diagnosed with Serious or Chronic, Progressive Illness (at any age)

Complete a POLST Form

End-of-Life Wishes Honored

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Benefits of ACP Discussions: The Patient’s Perspective

• Increases likelihood that wishes will be respected at end of life
• Achieves a sense of control
• Strengthens relationships
• Relieves burdens on loved ones
• Eases sharing of medical information (HIPPA)
• Provides opportunities to address life closure
ACP: What healthcare professionals need to hear from patients

- **Surrogate**
  - Who is to speak for the patient if incapacitated
- **Treatment wishes**
  - Such as resuscitation (CPR)
- **Values, Goals, Preferences**
  - What makes life worth living
  - What needs to be completed before death
  - What is unacceptable to the patient
    - “I’d rather die in comfort than ______.”
  - Special religious or cultural preferences
ACP: What patients need to hear from healthcare professionals

• Current state
  • Diagnoses
  • Threats to wellbeing and function
  • Expected trends and outcomes

• Treatment options
  • Benefits
  • Burdens
  • Likely results
  • Alternatives
Advance Care Planning process

• Gather and share information
• Select a spokesperson
• Discuss wishes with agent, loved ones, MD
• Complete advance directive document
• Give copies to agent, loved ones, MD
• Periodically review and make any changes
What is an Advance Health Care Directive?

• Tool to make health care wishes known if unable to communicate

• Allows a person to do either or both of the following:
  • Appoint a surrogate decision maker
    • (AKA Durable Power of Attorney for Health Care)
  • Give instructions for future health care decisions
    • (AKA Living Will)
Which document do I use?

• No single form for California
• Several to choose from
  • Statutory form
  • Simple versions
  • Five Wishes
  • DPAHC only
What makes the document legal?

- Individual’s signature
- Date of execution
- Witnesses or Notary
Two Witnesses

• Witness either
  • Signing of advance directive, or
  • Patient’s acknowledgment of his/her signature

• If you reside in a nursing home
  • One of the witnesses must be an ombudsman
Who Cannot be a Witness

- Neither Witnesses can be
  - Patient’s healthcare provider or employees of patient’s healthcare provider
  - Operator or employee of community care facility or assisted living facility
  - The agent named in the advance directive

- One of the Witnesses cannot be
  - Related to patient by blood, marriage, adoption
  - Entitled to a portion of the patient’s estate
Duration

• Advance directives have unlimited duration
  • Unless document states otherwise
California Recognizes

- Advance directives executed in another state in compliance with that state’s requirements
- Military advance directives
What is a verbal Advance Directive?

• When residing in healthcare institution
• Patient notifies supervising healthcare provider
• Provider documents in chart
• Good for lesser of stay or 60 days
Who will Speak for Me: Terms for Surrogate

- **Community Terms**
  - Surrogate / Decision maker / Spokesperson

- **Legal Terms**
  - Surrogate – verbal AD
  - Agent – written AD
  - Conservator – court order
  - Closest available relative
What is the Surrogate’s Role

• Legal Intent
  • Carry out the patient’s wishes
  • Make the decisions the patient would have made
  • Stand in the shoes of the patient

• Legal Standard
  • Make decisions in accordance with the patient’s expressed Wishes (substituted judgment)
  • To the extent not know, make decisions based on patient’s values and best interests
Scope of the Surrogate’s Authority

- Select and discharge healthcare providers
- Approve and disapprove tests, procedures
- Approve provision, withholding, withdrawal of medical treatment
- Donate organs
- Authorize autopsy
- Direct disposition of remains
- Review medical records
- Consent to HIV testing
When is the Surrogate’s Authority Effective

- When patient lacks capacity
- If the patient so designates in advance directive, immediately
Who Cannot be a Surrogate

• Patient’s supervising healthcare provider

• Employee of the healthcare institution where the patient receives care
  • Unless related to patient by blood, marriage, adoption, domestic partner

• Operator or employee of community care / assisted living facility where the patient lives
  • Unless related to patient by blood, marriage, adoption, domestic partner
Who do I choose as an agent?

- Willing and able
- Knows values and preferences
- Can make difficult decisions
- May or may not be the “closest” family member
What do I do with the document?

- Give copy to your agent.
- Make copies for other loved ones.
- Discuss with doctor; get in medical record.
- Keep a copy; take to hospital if you go.
- Photocopies are just as valid as original.
POLST: Physician Orders for Life-Sustaining Treatment

• Established in California in 2009
  • Started in Oregon about 20 years ago
• Medical Order
• Provides specific instructions concerning
  • Resuscitation (CPR)
  • Focus of medical interventions
  • Feeding tubes
• Legally binding across health care sites
• Valid only if appropriately signed
**Physician Orders for Life-Sustaining Treatment (POLST)**

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

<table>
<thead>
<tr>
<th>Patient Last Name:</th>
<th>Date Form Prepared:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient First Name:</td>
<td>Patient Date of Birth:</td>
</tr>
<tr>
<td>Patient Middle Name:</td>
<td>Medical Record #: (optional)</td>
</tr>
</tbody>
</table>

### A. Cardiopulmonary Resuscitation (CPR):

- [ ] Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- [ ] Do Not Attempt Resuscitation/DNR (Allow Natural Death)

### B. Medical Interventions:

- [ ] Comfort Measures Only: Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location.
- [ ] Limited Additional Interventions: In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital only if comfort needs cannot be met in current location.
- [ ] Full Treatment: In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

Additional Orders:

### C. Artificially Administered Nutrition:

- [ ] No artificial means of nutrition, including feeding tubes. Additional Orders:
- [ ] Trial period of artificial nutrition, including feeding tubes:
- [ ] Long-term artificial nutrition, including feeding tubes:

### D. Information and Signatures:

- [ ] Patient (Patient Has Capacity) 
- [ ] Legally Recognized Decisionmaker

Advance Directive dated ______ available and reviewed →

Health Care Agent if named in Advance Directive:

Name: ____________________________

Phone: ____________________________

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name: ____________________________

Physician Phone Number: ____________________________

Physician License Number: ____________________________

Physician Signature: (required) ____________________________ Date: ______

**Signature of Patient or Legally Recognized Decisionmaker**

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

Print Name: ____________________________

Relationship: (write self if patient) ____________________________

Signature: (required) ____________________________ Date: ______

Address: ____________________________

Daytime Phone Number: ____________________________

Evening Phone Number: ____________________________

**Send Form With Person Whenever Transferred Or Discharged**
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information
Name (last, first, middle): Date of Birth: Gender: M F

Health Care Provider Assisting with Form Preparation
Name: Title: Phone Number:

Additional Contact
Name: Relationship to Patient: Phone Number:

Directions for Health Care Provider

Completing POLST
- Completing a POLST form is voluntary. California law requires that a POLST form be followed by health care providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient’s physician believes best knows what is in the patient’s best interest and will make decisions in accordance with the patient’s expressed wishes and values to the extent known.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or treatments may prohibit a person from residing in a residential care facility for the elderly.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient’s medical record, on Ultra Pink paper when possible.

Using POLST
- Any incomplete section of POLST implies full treatment for that section.
Section A:
- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a person who has chosen “Do Not Attempt Resuscitation.”
Section B:
- When comfort cannot be achieved in the current setting, the person, including someone with “Comfort Measures Only,” should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not “Comfort Measures.”
- Treatment of dehydration prolongs life. If person desires IV fluids, indicate “Limited Intervention” or “Full Treatment.”
- Depending on local EMS protocol, “Additional Orders” written in Section B may not be implemented by EMS personnel.

Reviewing POLST
It is recommended that POLST be reviewed periodically. Review is recommended when:
- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person’s health status, or
- The person’s treatment preferences change.

Modifying and Voiding POLST
- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing “VOID” in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the individual or, if unknown, the individual’s best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit www.caPOLST.org

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
POLST vs. Advance Healthcare Directive

- POLST *complements* the Advance Healthcare Directive (AHCD).
- Both are legal documents.
## POLST vs. Advance Healthcare Directive

<table>
<thead>
<tr>
<th>POLST</th>
<th>AHCD</th>
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</thead>
<tbody>
<tr>
<td>For seriously ill/frail, at any age</td>
<td>For anyone 18 and older</td>
</tr>
<tr>
<td>Specific orders for <em>current</em> treatment</td>
<td>General instructions for <em>future</em> treatment</td>
</tr>
<tr>
<td>Can be signed by decisionmaker</td>
<td>Appoints decisionmaker</td>
</tr>
</tbody>
</table>
## POLST vs. Pre-Hospital DNR (Do Not Resuscitate)

<table>
<thead>
<tr>
<th>POLST</th>
<th>Pre-Hospital DNR</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Allows for choosing resuscitation</td>
<td>• Can only use if choosing DNR</td>
</tr>
<tr>
<td>• Allows for other medical treatments</td>
<td>• Only applies to resuscitation</td>
</tr>
<tr>
<td>• Honored across all health care settings</td>
<td>• Only honored outside the hospital</td>
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Who Can Help Complete POLST?

• Healthcare Providers
  • Licensed, certified, or otherwise authorized to provide healthcare in the normal course of business

• Best practice suggests use of those trained in the POLST Conversation
  • Physicians
  • Nurses
  • Social Workers
  • Chaplains
  • Social Service Designees
Keeping Wishes Up to Date

• Review and Update Documents
  • Important life changes
    • Marriage, birth, divorce, death
  • Major change in health status
  • Change in treatment preferences
What If I Change My Mind

- Individual
  - Can modify or revoke his/her wishes at anytime for any reason

- Agent
  - Agent’s job is to carry out individual’s wishes

- Process
  - Best practice is to execute a new document
Keeping Documents

• Share a copy with your agent & loved ones
• Give a copy to your doctor
• Keep it in easy-to-find location at home
Hospice

• What is it
  • Team of healthcare providers
  • Focused on symptoms, comfort, quality of life
  • Support patient and family
  • Come into your home

• Restrictions
  • Six months prognosis
  • Forego curative treatment

• Structured as medical benefit
Palliative Care

• What is it
  • Specialized medical care for people with serious illnesses
  • Focuses on relief from symptoms, pain & stress
  • Goal is to improve quality of life for both patient & family
  • Appropriate at any age and at any stage in a serious illness
  • Can be provided along with curative treatment
• Structured as philosophy of care
Questions?