ADVANCE CARE PLANNING: A QUALITY IMPERATIVE FOR PATIENT-CENTERED CARE

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VERMONT ETHICS NETWORK
Advancing Health Care Ethics

FACTS

- 90% of people say that talking with their loved ones about end-of-life care is important
  - 27% have actually done so
- 82% of people say it is important to put their wishes in writing
  - 23% have actually done so

Sources: Conversation Project National Survey (2013); and Survey of Californians by the California HealthCare Foundation (2012).

FACT

- 80% of people say that if they were seriously ill they would want to talk to their doctor about end-of-life care

- 7% report having had an end-of-life conversation with their doctor

Source: Survey of Californians by the California HealthCare Foundation (2012)

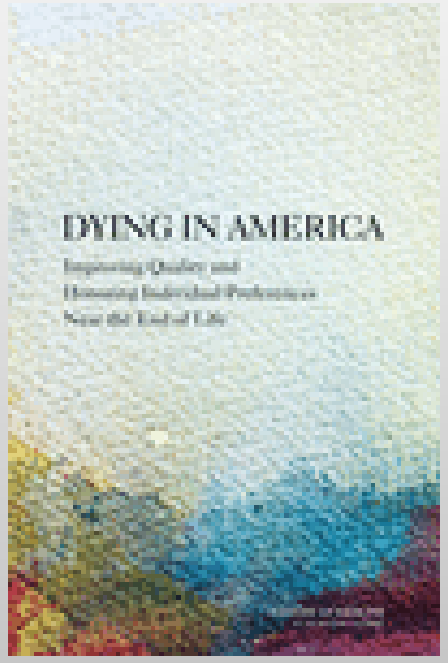
FACT

- The completion of advance directives has made a significant impact in patient/family outcomes and health care costs in La Crosse, Wisconsin.

- With the systematic integration of their *Respecting Choices* program, La Crosse spends less on health care for patients at the end-of-life than any other place in the country, according to the Dartmouth Health Atlas.

(http://www.npr.org/sections/money/2014/03/05/286126451/living-wills-are-the-talk-of-the-town-in-la-crosse-wis)

Institute of Medicines' *Dying in America* Report



"The IOM committee believes a person-centered family-oriented approach that honors individual preferences and promotes quality of life through the end of life should be a national priority."

www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx

IOM Report Calls For:

- Coverage, by both government & private health insurers, of comprehensive care for patients with advanced serious illnesses who are nearing the end of life.
- The development of quality metrics and standards for clinician-patient communication and advance care planning, with insurance reimbursement tied to performance on these standards.
- Federal and regulatory action to establish financial incentives for integrating medical and social services for people nearing the end of life, including electronic health records that incorporate advance care planning.
- Widespread efforts to provide information to the public on the benefits of advance care planning, and the ability for individuals to choose their own course of treatment.

The Joint Commission: Patient Safety Recommendations

Health care organizations can help protect patients from potential harm and provide better, higher quality end-of-life care by doing the following:

- Create a framework for classifying patient safety practices in end-of-life planning focused on communication and care planning.
- Support and train clinicians to conduct advance care planning, to ensure that the planning is what matters to the patient, and that the dignity of the patient is maintained and respected.
- Provide clinicians with the information they need to conduct advance care planning conversations with their patients.

http://www.jointcommission.org/issues/article.aspx?Article=UFJ6bbHhCrjKk9%2f4%2fHvwwBzgZpRvRaJVXx2HgTRD6Oc%3d&j=2601717&e=bonni.martin@vtmednet.org&l=9552_HTML&u=50478276&mid=1064717&jb=0

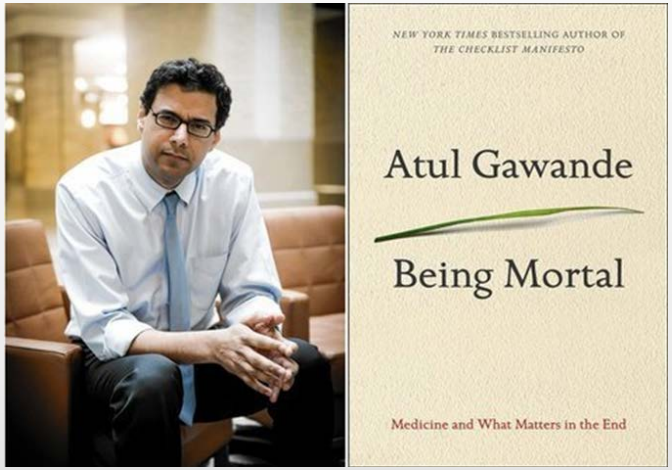
Institute for Health Improvement (IHI)

"Conversation ready": A framework for patient-centered care and patient safety at the end of life. Key principles:

- **Engage** with patients and families to understand what matters most to them at the end of life.
- **Steward** information about each patient's end of life wishes as reliably as we do allergy information.
- **Respect** people's wishes for care at the end of life by partnering to develop a patient-centered plan of care.
- **Exemplify** this work in our own lives, so that we finally understand the benefits and challenges.
- **Connect** in manner that is culturally and individually respectful of each patient. Patient-centered, end-of-life care must account for cultural influences, such as religion, ethnicity, socioeconomic status, educational levels and location.

http://www.ihi.org/Engage/Initiatives/ConversationProject/Pages/ConversationReady.aspx

Dr. Atul Gawande: *Being Mortal*



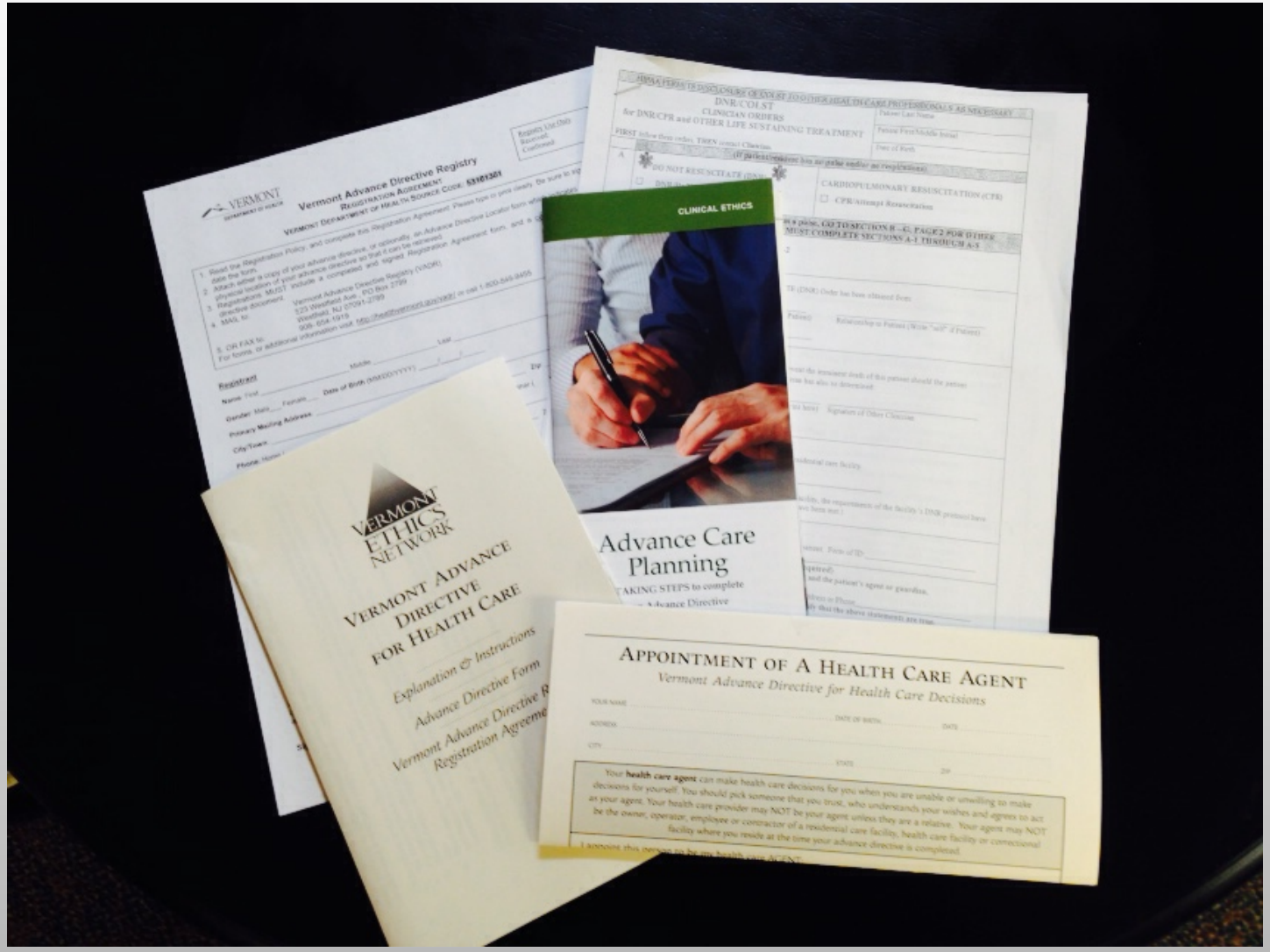
"Our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one's story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone's lives."

ADVANCE CARE PLANNING IS A PROCESS – *TAKING STEPS*

A Step-Wise Approach

- Step 1: Appoint a Health Care Agent
- Step 2: Complete an Advance Directive with information about treatment goals and health care priorities
- Step 3: Develop a COLST to ensure that any limitation of treatment preferences will be respected across care settings

Available Tools



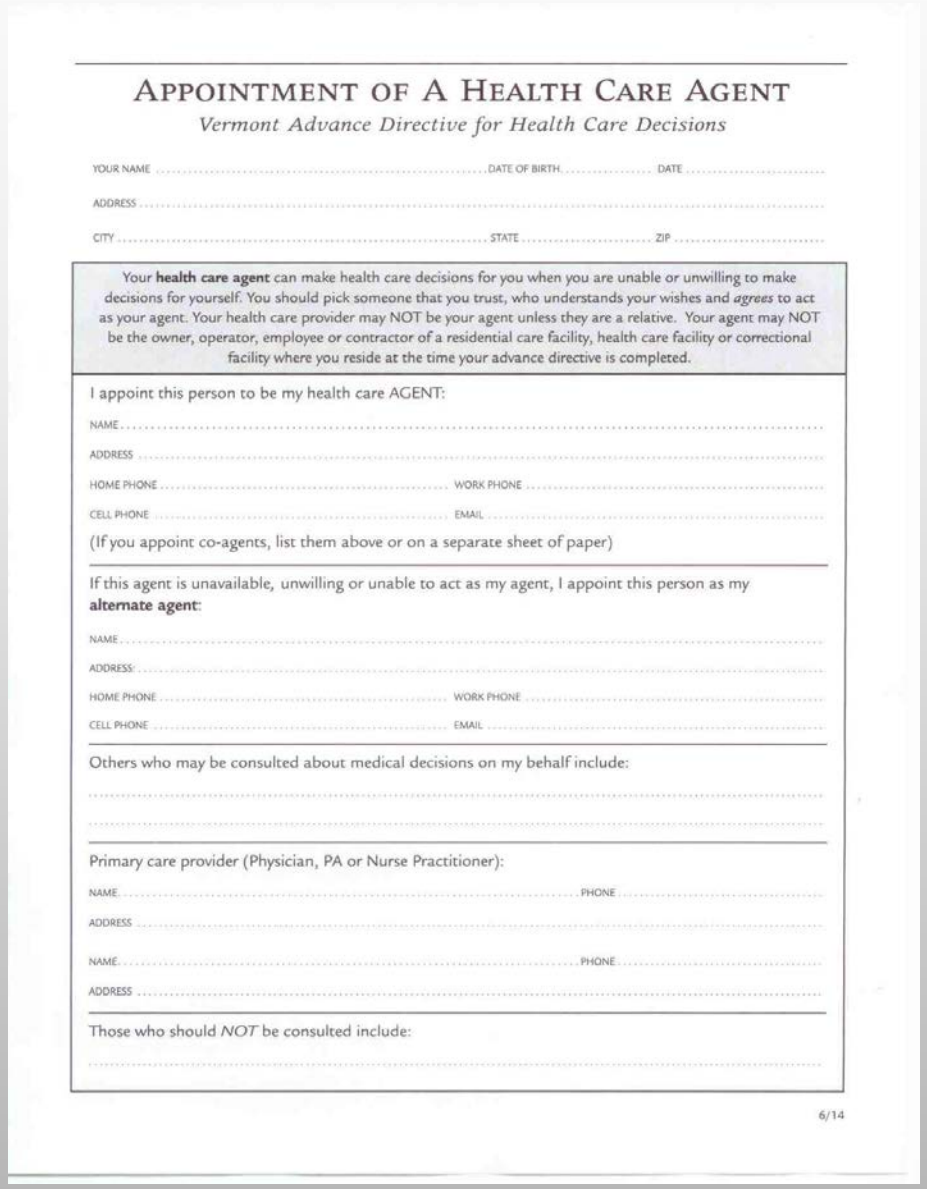
Medical Decision-Making Tools

- Appointing a Health Care Agent Form
- Vermont Advance Directive for Health Care
  Includes Proxy and Treatment Directives (short & long forms)
- Vermont Advance Directive Registry
- DNR/COLST Orders

Step 1– Appointing a Health Care Agent

- Designate a health care decision-maker(s)
  - Health Care Agent(s)/Durable Power of Attorney for Health Care
- Provide information about others who may and/or may not be consulted about medical decisions; general health care goals and contact information for primary care provider
- Signature & witnessing

NEW: Form for Appointing an Agent



APPOINTMENT OF A HEALTH CARE AGENT

Vermont Advance Directive for Health Care Decisions

YOUR NAME ..... DATE OF BIRTH ..... DATE .....

ADDRESS .....

CITY ..... STATE ..... ZIP .....

Your **health care agent** can make health care decisions for you when you are unable or unwilling to make decisions for yourself. You should pick someone that you trust, who understands your wishes and *agrees* to act as your agent. Your health care provider may NOT be your agent unless they are a relative. Your agent may NOT be the owner, operator, employee or contractor of a residential care facility, health care facility or correctional facility where you reside at the time your advance directive is completed.

I appoint this person to be my health care AGENT:

NAME .....

ADDRESS .....

HOME PHONE ..... WORK PHONE .....

CELL PHONE ..... EMAIL .....

(If you appoint co-agents, list them above or on a separate sheet of paper)

If this agent is unavailable, unwilling or unable to act as my agent, I appoint this person as my **alternate agent**:

NAME .....

ADDRESS: .....

HOME PHONE ..... WORK PHONE .....

CELL PHONE ..... EMAIL .....

Others who may be consulted about medical decisions on my behalf include:

.....

.....

Primary care provider (Physician, PA or Nurse Practitioner):

NAME ..... PHONE .....

ADDRESS .....

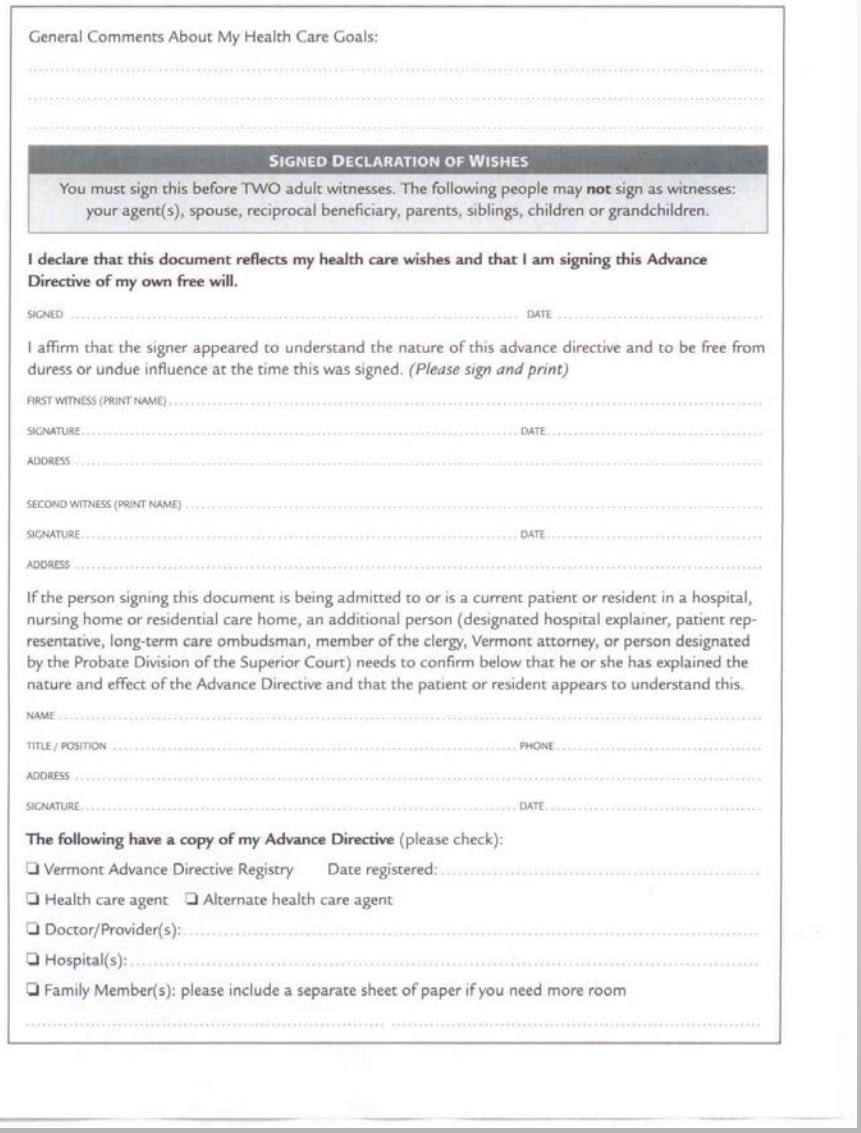
NAME ..... PHONE .....

ADDRESS .....

Those who should *NOT* be consulted include:

.....

6/14



General Comments About My Health Care Goals:

.....

.....

.....

SIGNED DECLARATION OF WISHES

You must sign this before TWO adult witnesses. The following people may **not** sign as witnesses: your agent(s), spouse, reciprocal beneficiary, parents, siblings, children or grandchildren.

I declare that this document reflects my health care wishes and that I am signing this Advance Directive of my own free will.

SIGNED ..... DATE .....

I affirm that the signer appeared to understand the nature of this advance directive and to be free from duress or undue influence at the time this was signed. *(Please sign and print)*

FIRST WITNESS (PRINT NAME) .....

SIGNATURE ..... DATE .....

ADDRESS .....

SECOND WITNESS (PRINT NAME) .....

SIGNATURE ..... DATE .....

ADDRESS .....

If the person signing this document is being admitted to or is a current patient or resident in a hospital, nursing home or residential care home, an additional person (designated hospital explainer, patient representative, long-term care ombudsman, member of the clergy, Vermont attorney, or person designated by the Probate Division of the Superior Court) needs to confirm below that he or she has explained the nature and effect of the Advance Directive and that the patient or resident appears to understand this.

NAME .....

TITLE / POSITION ..... PHONE .....

ADDRESS .....

SIGNATURE ..... DATE .....

The following have a copy of my Advance Directive (please check):

❑ Vermont Advance Directive Registry Date registered: .....

❑ Health care agent ❑ Alternate health care agent

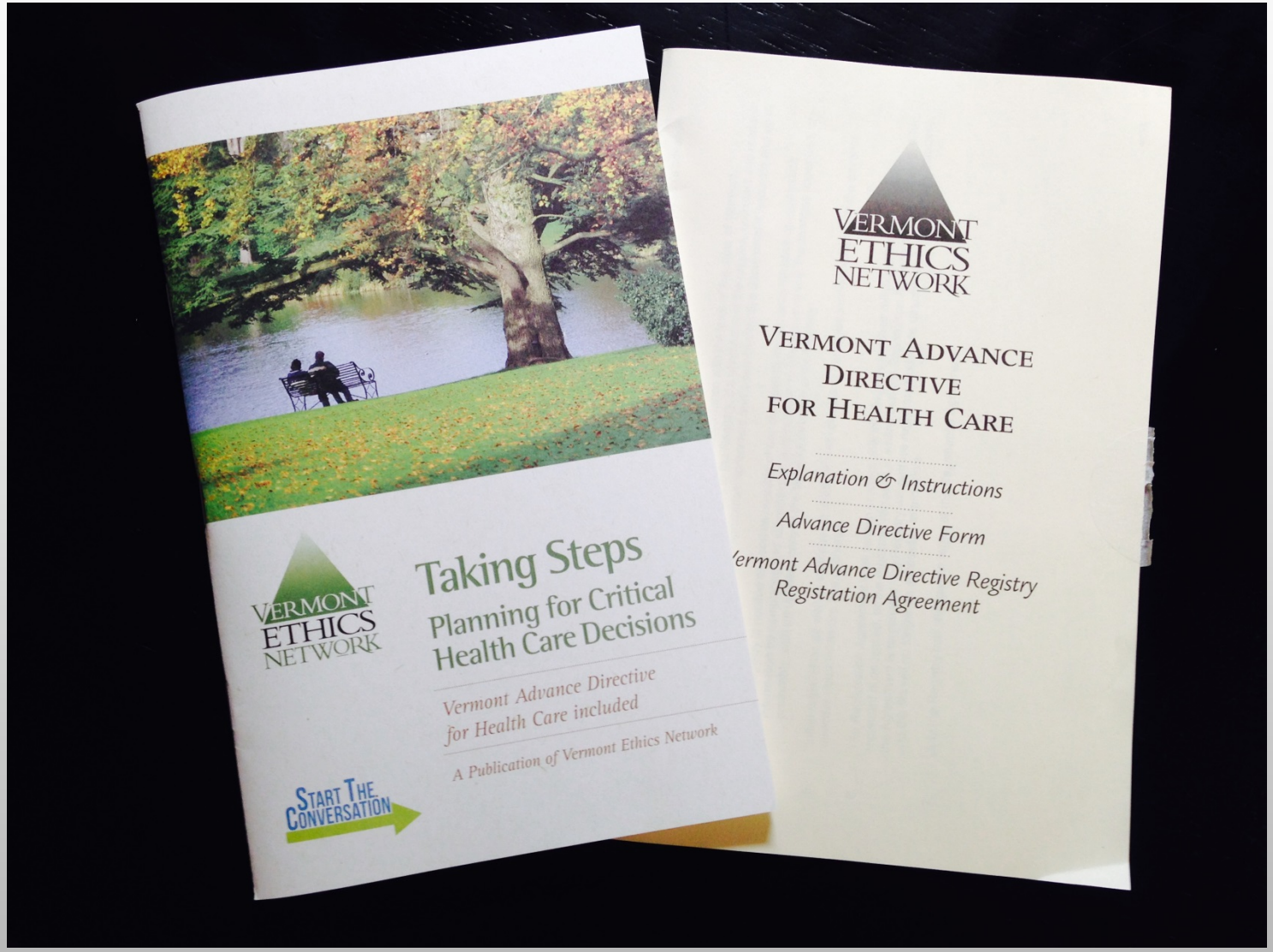
❑ Doctor/Provider(s): .....

❑ Hospital(s): .....

❑ Family Member(s): please include a separate sheet of paper if you need more room

.....

Taking Steps Booklet – AD Short Form



Step 2: Vermont Advance Directive for Health Care – Short Form

- Still provides section to appoint a health care agent (Part 1)
  (ie. Durable Power of Attorney for Health Care/Proxy)
- Provides expanded opportunity for information about health care goals, values & preferences for treatment (Parts 2 &3)
  (Treatment directive)
- Allow for information to be provided about organ donation, funeral, cremation and burial arrangements (PART 4)
- Signature & witnessing (PART 5)

Advance Directive Long Form

- A more comprehensive form that allows for more specificity if that is desired
- Has 9 parts instead of 5
- Includes:
  - Mental Health Considerations (i.e. emergency involuntary treatment, electro-convulsive therapy)
  - Waiver of Right to Request or Object to Treatment (Ulysses Clause)

The Vermont AD Registry (VADR)

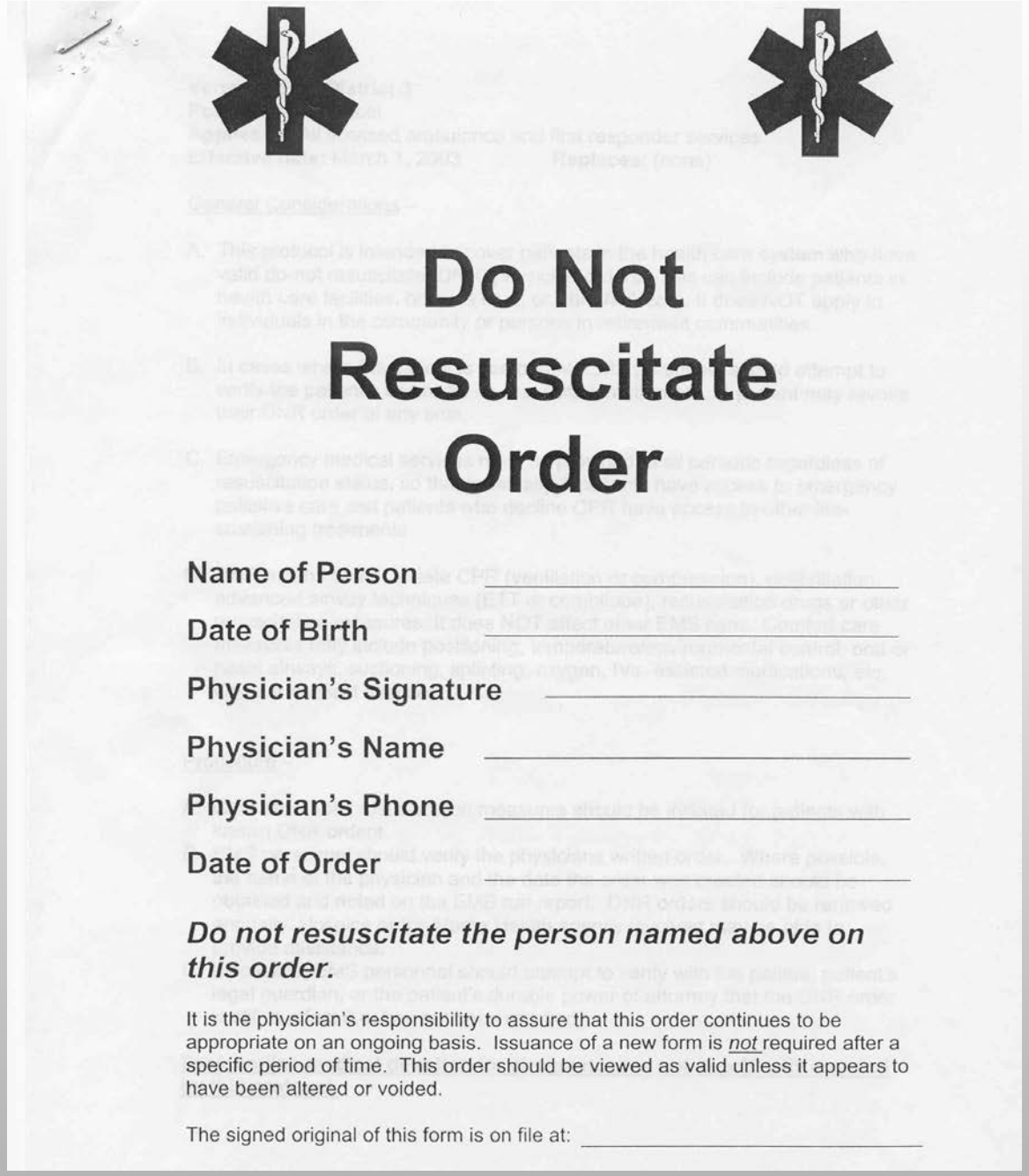
- VADR is free for Vermont residents
- Electronic storage for Advance Directive documents
- Hospitals are required to check the registry when a patient who lacks capacity is brought in
- Form for submitting documents to registry & for making changes once a document has been submitted
  - Registry Agreement
  - Authorization to Change Form

Step 3: Limitation of Treatment Orders

- **POLST** (Physician Orders for Life-Sustaining Treatment)
  - National: outpatient/transportable orders
- **VERMONT COLST (Clinician Orders for Life-Sustaining Treatment)**
  - **Vermont adaptation of POLST; Designed to be portable across care settings**
- **MOLST** (Medical Orders for Life-Sustaining Treatment)
  - New York & Massachusetts equivalent of POLST

Old Form

Does not meet the statutory requirement for a valid DNR order as there is no place to document informed consent, etc.



Do Not Resuscitate Order

Name of Person _____

Date of Birth _____

Physician's Signature _____

Physician's Name _____

Physician's Phone _____

Date of Order _____

Do not resuscitate the person named above on this order.

It is the physician's responsibility to assure that this order continues to be appropriate on an ongoing basis. Issuance of a new form is *not* required after a specific period of time. This order should be viewed as valid unless it appears to have been altered or voided.

The signed original of this form is on file at: _____

Page One: Code Status

HIPAA PERMITS DISCLOSURE OF COLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

DNR/COLST
CLINICIAN ORDERS
for DNR/CPR and OTHER LIFE SUSTAINING TREATMENT

FIRST follow these orders, **THEN** contact **Clinician.**

Patient Last Name

Patient First/Middle Initial

Date of Birth

(If patient/resident has no pulse and/or no respirations)

A

DO NOT RESUSCITATE (DNR)

☐ **DNR/Do Not Attempt Resuscitation (Allow Natural Death)**

CARDIOPULMONARY RESUSCITATION (CPR)

☐ **CPR/Attempt Resuscitation**

For patient who is breathing and/or has a pulse, GO TO SECTION B – G, PAGE 2 FOR OTHER INSTRUCTIONS. CLINICIANS MUST COMPLETE SECTIONS A-1 THROUGH A-5

A-1 Basis for DNR Order
Informed Consent - Complete Section A-2
Futility - Complete Section A-3

A-2 Informed Consent
Informed Consent for this DO NOT RESUSCITATE (DNR) Order has been obtained from:

_____ _____
Name of Person Giving Informed Consent (Can be Patient) Relationship to Patient (Write "self" if Patient)

_____
Signature (If Available)

A-3 Futility (required if no consent)

☐ I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined:

_____ _____
Name of Other Clinician Making this Determination (Print here) Signature of Other Clinician

Dated:_____

A-4 Facility DNR Protocol (required if applicable)

This patient is ☐ is not ☐ in a health care facility or a residential care facility.

Name of Facility:_____

If this patient is in a health care facility or a residential care facility, the requirements of the facility's DNR protocol have been met._____ (Initial here if protocol requirements have been met.)

A-5 DNR Identification (optional)

I have authorized issuance of a DNR Identification (ID) to this patient. Form of ID:_____

Certification and signature for DNR

A-6 Clinician Certifications and Signature for CPR/DNR (required)
I have consulted, or made an effort to consult with the patient and the patient's agent or guardian.

Patient's Agent or Guardian_____Address or Phone_____
I certify that I am the clinician for the above patient, and I certify that the above statements are true.

_____ _____
Signature of Clinician Printed Name of Clinician

Dated:_____

Page Two :

Mechanical ventilation

Hospital transfer

Antibiotics

Tube feedings and TPN

Goals of care

ORDERS FOR OTHER LIFE-SUSTAINING TREATMENT
(If patient/resident is breathing and/or has pulse)

B **INTUBATION AND MECHANICAL VENTILATION INSTRUCTIONS:**

If patient has DNR order and has progressive or impending pulmonary failure without acute cardiopulmonary arrest:

- ☐ Do Not Intubate/Multi-Lumen Airway (DNI)
- ☐ Trial Period of Intubation/Multi-Lumen Airway and ventilation
- ☐ Intubation/Multi-Lumen Airway and long-term mechanical ventilation if needed

C **TRANSFER TO HOSPITAL**

- ☐ Do not transfer unless comfort care needs cannot be met in current location or if severe symptoms cannot be otherwise controlled
- ☐ Transfer

D **ANTIBIOTICS**

- ☐ No antibiotics. Use other measures to relieve symptoms
- ☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal
- ☐ Use antibiotics

E **ARTIFICIALLY ADMINISTERED NUTRITION:** Offer food and liquids by mouth if feasible.

Feeding tube

- ☐ No feeding tube
- ☐ Trial period of feeding tube (Goal:_____)
- ☐ Long-term feeding tube

Parenteral nutrition or hydration (e.g. IV fluids or Total Parenteral Nutrition)

- ☐ No parenteral nutrition or hydration
- ☐ Trial period of parenteral nutrition or hydration (Goal:_____)
- ☐ Long term parenteral nutrition or hydration

F **MEDICAL INTERVENTIONS:**

- ☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Offer food and fluids by mouth, if feasible.
- ☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatments and IV fluids as indicated. *Avoid intensive care if possible.*
- ☐ **FULL TREATMENT** Includes care described above. Use defibrillation and intensive care as indicated.

DNR/COLST Orders & Advance Directives

- DNR/COLST orders are NOT a replacement for Advance Directives.
- AD's provide important information beyond that of DNR and limitations of treatment. AD's do not require informed consent, or discussion of risks, benefits and alternatives.
- DNR/COLST is intended to be used in conjunction with AD's for those individuals for whom it is medically appropriate (such as people living with chronic and/or life limiting illness or those for whom).

"Whenever serious sickness or injury strikes and your body or mind breaks down, the vital questions are the same: What is your understanding of the situation and its potential outcomes? What are your fears and what are your hopes? What are the trade-offs you are willing to make and not willing to make? And what is the course of action that best serves this understanding?"

Atul Gawande, *Being Mortal: Medicine and What Matters in the End*

Resources


WAKE UP TO DYING PROJECT
An Awareness and Action Campaign
VERMONT ETHICS NETWORK
Welcome
START THE CONVERSATION
WHERE DO I BEGIN?
IT'S TIME TO TALK.
Dartmouth-Hitchcock
HONORING DECISIONS WHEN DECISIONS MATTER MOST
Speak Sooner
ABOUT THE CENTER FOR COMMUNICATION IN MEDICINE
"Mission is the intersection of your passion and the world's need" Aristotle

"Sometimes we can offer a cure, sometimes only a salve, sometimes not even that. But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the larger aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it the good we do can be breathtaking."

Atul Gawande, *Being Mortal: Medicine and What Matters in the End*