MiCMRC Educational Webinar

Advance Care Planning (ACP) 101

May 23, 2018

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The Michigan Care Management Resource Center

MiCMRC Educational Webinar

Advance Care Planning (ACP) 101

Expert Presenter:

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ACP Michigan


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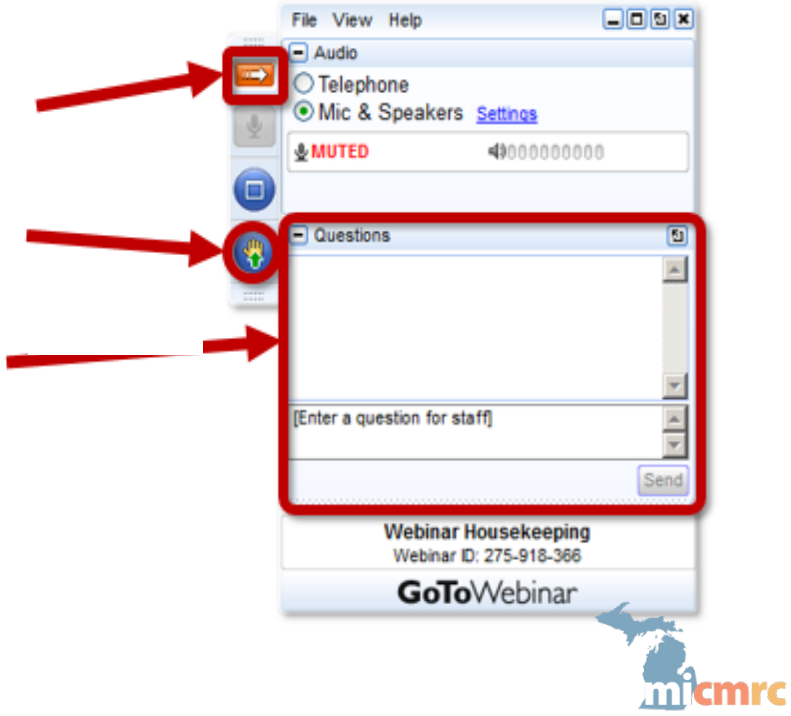

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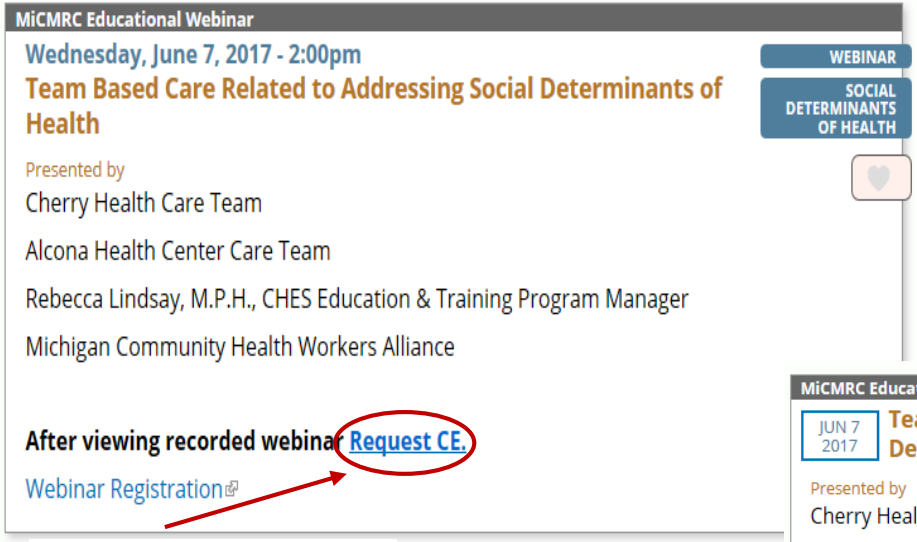

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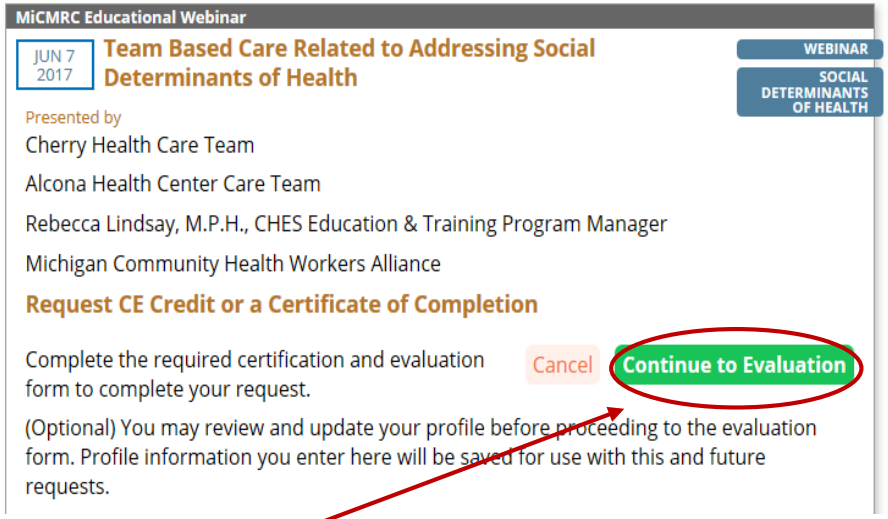

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Advance Care Planning (ACP) 101

Carolyn Stramecki, MHSA, CPHQ
ACP Michigan

Objectives

- Define ACP
- Explain the ACP step model
- Describe Michigan law related to ACP
- Explain ACP tools

What is ACP?

Advance Care Planning

- ACP is a *process of communication* that helps individuals
  - understand their choices for future healthcare
  - reflect on personal goals, values, religious, or cultural beliefs
  - talk to physicians, healthcare agents, and other loved ones

- Built upon a shared decision-making approach

Desired Outcomes of Advance Care Planning

Ideally to "know" and to "honor" a patient's informed plans, by…

1. Creating an effective plan, including:
   a) selecting a well-prepared Patient Advocate when possible, and
   b) creating specific instructions that reflect informed decisions that are geared to the person's state of health.
2. Having these plans available to the treating physician.
3. Incorporating plans into medical decisions when needed, wherever needed.

For ACP to Be Successful…

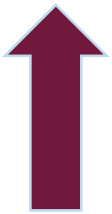
Plans must be

- **Created**—high prevalence is essential
- **Specific** enough for the clinical situation
- **Accurately** reflect the individual's preferences
- **Understandable** to those making decisions
- **Available** to the decision makers
- **Incorporated** into decisions, as needed

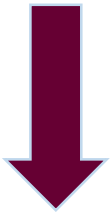
(Fagerlin and Schneider, 2004)

Importance of ACP

Those who have participated in advance care planning conversations are significantly more likely to have their decisions understood by their healthcare agents, and three times more likely to have their wishes followed.



- Satisfaction with quality of care
- Use of Hospice
- Likelihood patient die place prefer
- Healthcare professionals understand wishes



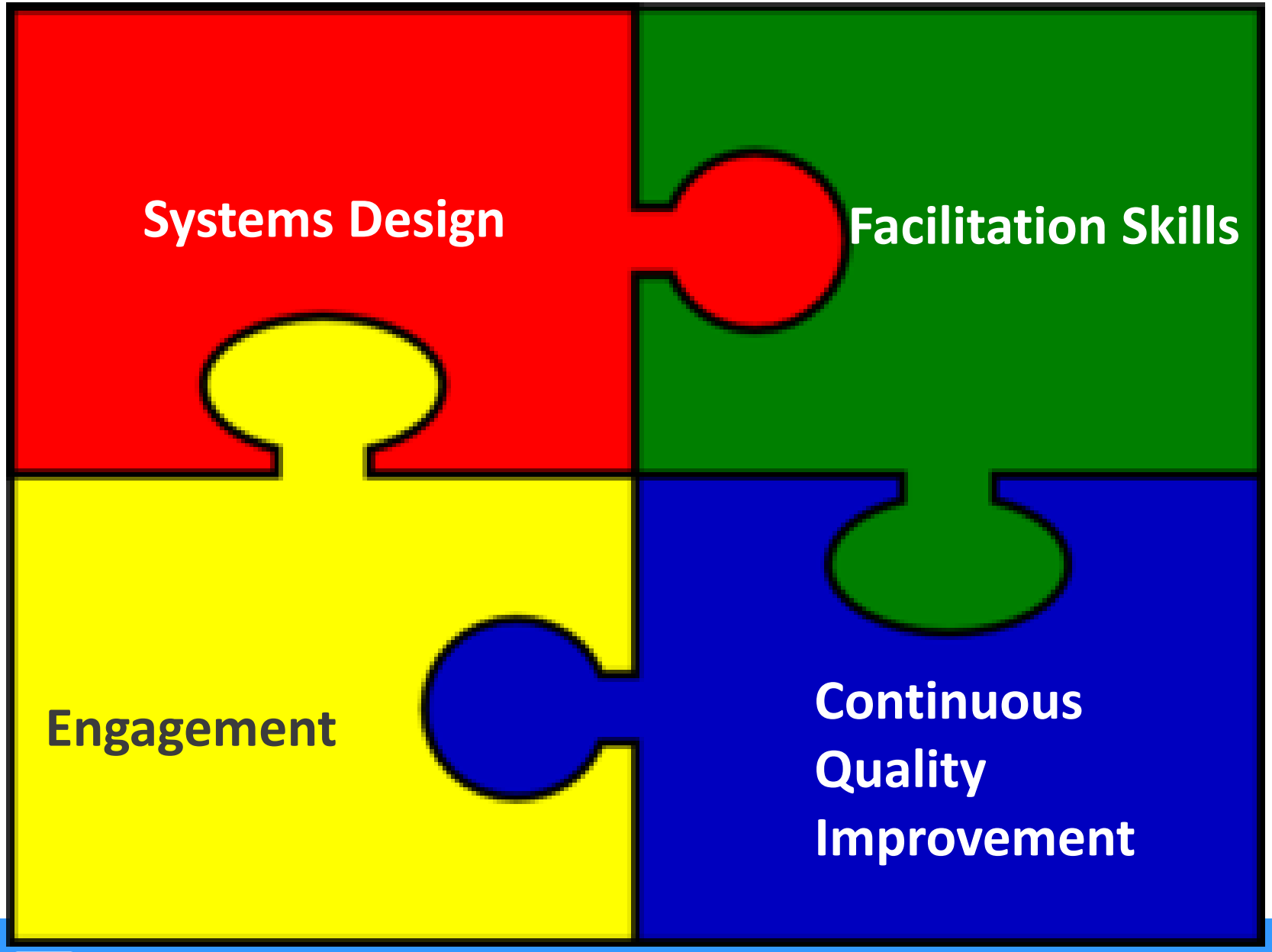
- Hospitalization at end of life
- Reduced family decisional burden
- Family emotional stress with difficult decision
- Less intensive treatment end-of-life
- Less complicated family grief following death of loved one

"I have an advance directive, not because I have a serious illness, but because I have a family."

Ira Byock, MD

Common Gaps

- Everyone is confused about the documents!
- Ours systems don't support ACP
  - Technology
  - Processes
  - Education & training
- Patient Advocates are not prepared
- Documents aren't specific or updated
- Documents contain ambiguous statements or phrases that are difficult to interpret in the clinical setting
- Difficult to engage

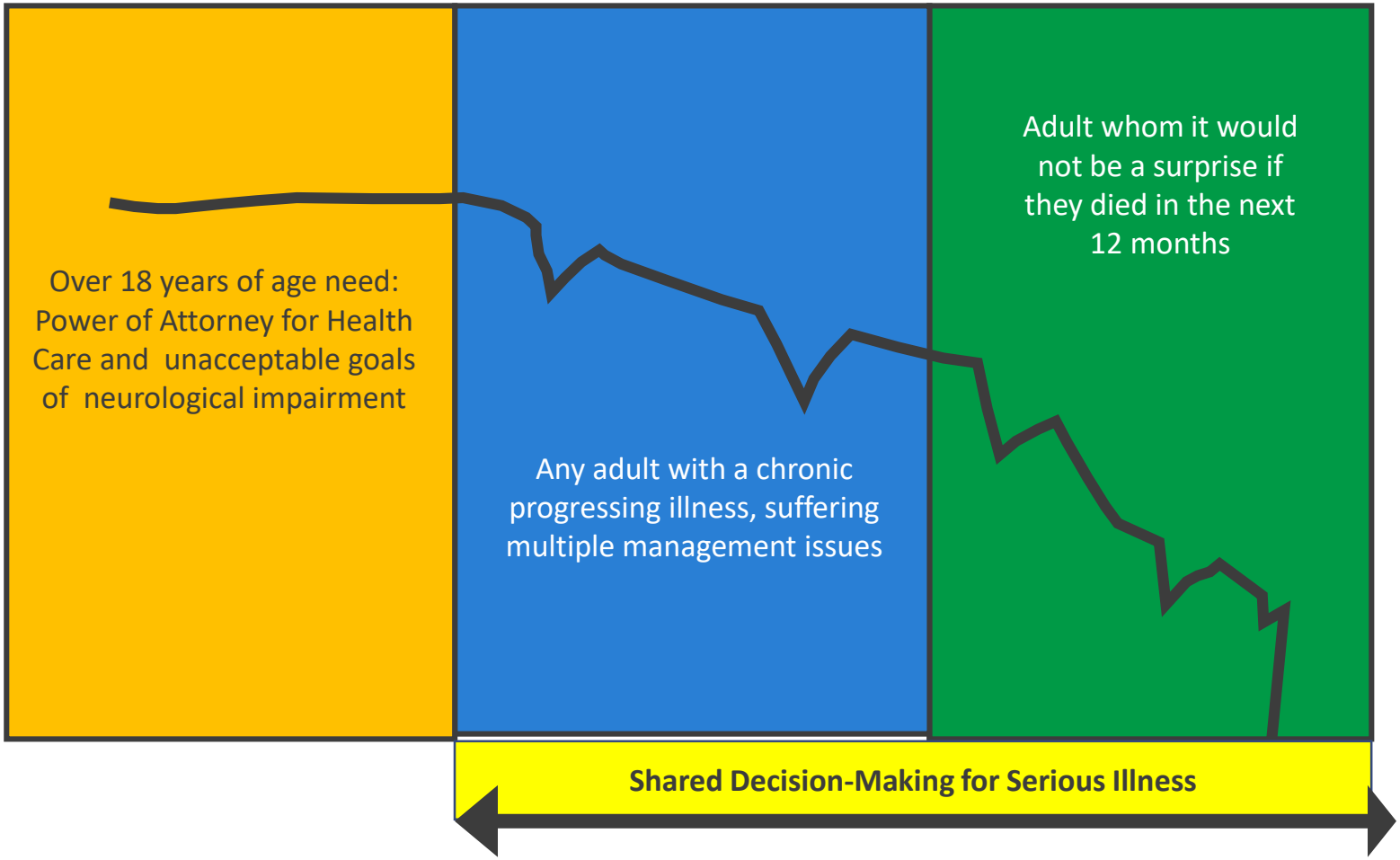

Systems Design
Facilitation Skills
Engagement
Continuous
Quality
Improvement

The stages of ACP

Planning is best done in stages

- Attempting to plan for ALL possibilities in a single document is both impossible and unnecessary.
- Planning has three distinguishable, focused stages:
  1. Basic planning…this type of planning is useful for all adults, but should start by ages 55 to 65 for healthy adults.
  2. Planning for those with life-limiting, progressive illness where complications are evident.
  3. End-stage disease where it would not be surprising if the patient died in the next 12 months.

Advance Care Planning For Most Adults



ACP Tools

Basic Tools

- Advance Directive/Designation Of Patient Advocate Form
  - Legal piece: designates a Patient Advocate and successors
  - Information piece describes an individuals wishes for future healthcare
- Out-of-Hospital DNR
  - Any individual over 18
  - Medical order to not perform resuscitations
  - MI DNR Procedures Act; direct EMS
- Physician Orders for Scope of Treatment (POST)
  - Medical order
  - Medically frail “advanced illness”
  - Directs EMS and other organizations, advisory in Acute Care

Advance Directive

- Designation of Patient Advocate: written document that names an individual to make healthcare decisions as an extension of the patient, should the patient lose the ability to make healthcare decisions
  - ➢This is the LEGAL document in Michigan

- Living Will: A written document in which individual inform doctors, family members and others what type of medical care he/she wishes to receive should he/she become terminally ill or permanently unconscious.
  - ➢This document is great information

MakingChoicesMichigan

Advance Directive

Durable Power of Attorney for Healthcare
(Patient Advocate Designation)

Introduction

This document provides a way for an individual to create a Durable Power of Attorney for Healthcare (Patient Advocate Designation) and other documentation that will meet the basic requirements for this state.

This **Advance Directive** allows you to appoint a person (and alternates) to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **Patient Advocate**. This document gives your Patient Advocate authority to make your decisions only when you have been determined unable to make your own decisions by two physicians, or a physician and a licensed psychologist.

It does not give your Patient Advocate any authority to make your financial or other business decisions.

Before completing this document, take time to read it carefully. It also is very important that you discuss your views, your values, and this document with your Patient Advocate. If you do not closely involve your Patient Advocate, and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

This document was developed to meet the legal requirements of Michigan. It is not designed to replace the counsel of your attorney.

This is an Advance Directive for *(print legibly)*:

Name: _____ Date of Birth: _____ Last 4 digits of SSN: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

Address: _____

City/State/Zip: _____

Where I would like to receive hospital care (whenever possible): _____

Out of Hospital DNR

- As per MI DNR Procedures Act
  - Statutory protection for emergency personnel, by the Michigan Do Not Resuscitate (DNR) Procedures Act
  - The Michigan DNR Procedures Act allows for the use of a DNR bracelet in the community
  - Deals only with cardio-pulmonary resuscitation (CPR) in event of absence of heartbeat and breathing
  - Can only be executed by the individual or his/her legally designated patient advocate
  - Anyone 18+

Patient Name: _____ Date of Birth:_____

DO-NOT-RESUSCITATE ORDER

I have discussed my health status with my physician _____.
(Physician's Name)

A. PATIENT CONSENT

I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order will remain in effect until it is changed by me. I know that I can change this order at any time by telling someone or writing to my caretaking family, doctor or patient advocate.

Being of sound mind, I voluntarily execute this order, and I understand its full meaning.

_____ _____
(Patient's signature) (Date)

_____
(Type or print Patient's name)

B. PATIENT ADVOCATE CONSENT

I authorize that in the event the patient's heart and breathing should stop, no person shall attempt to resuscitate the patient. I understand the full meaning of this order and assume responsibility for its execution. This order will remain in effect until it is changed by me. I know that I can change this order at any time by telling someone or writing to my caretaking family, doctor or patient advocate.

_____ _____
(Patient advocate's signature) (Date)

_____
(Type or print patient advocate's name)

C. GUARDIAN CONSENT

I authorize that in the event the ward's heart and breathing should stop, no person shall attempt to resuscitate the ward. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law.

_____ _____
(Guardian's signature) (Date)

_____
(Type or print guardian's name)

PHYSICIAN SIGNATURE

_____ _____
(Physician's signature) (Date)

_____
(Type or print physician's full name)

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence.

_____ _____
(Witness 1 signature) (Date) (Witness 2 signature) (Date)

_____ _____
(Type or print witness's name) (Type or print witness's name)

THIS FORM WAS PREPARED PURSUANT TO, AND IS IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT.

Physician orders for Scope of Treatment (POST)

- Established by Public Act 154 (2017)
- A **medical order** designed to improve end of life care by converting patients' treatment decisions into medical orders that are transferable throughout the healthcare system
- Is a standard of care for communicating the scope of treatment decisions
- For frail elders or others whose death in the next 12 months would not be surprising.
- Is always voluntary

Michigan Physician Orders for Scope of Treatment (MI-POST)

First follow these orders, then contact physician. This is a Medical Order Sheet based on the person's medical condition and treatment decisions. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name		
First Name/Middle Initial		
Date of Birth: (mm/dd/yyyy)	Gender: (circle) M F	Last 4 SSN:

A — CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse AND is not breathing.

Check one

☐ Attempt Resuscitation/CPR ☐ DO NOT Attempt Resuscitation/CPR (DNR/No CPR)

B — MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

Check one

ALL patients will receive comfort measures.

☐ **Advanced Interventions:** Use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion and other advance interventions as medically indicated.
Transfer to hospital if indicated; includes intensive care.

☐ **Limited Interventions:** DO NOT use intubation, advanced invasive airway interventions, or mechanical ventilation. Use medical treatment, IV fluids and cardiac monitor as indicated.
Transfer to hospital if indicated. Avoid intensive care.

☐ **Comfort Measures Only:** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction manual treatment of airway obstruction and non-invasive respiratory assistance as needed for comfort.
Only transfer to hospital if comfort needs cannot be met in current location.

Additional orders: _____

_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.

Check one

☐ Long-term artificial nutrition
☐ Defined trial period of artificial nutrition
☐ No artificial nutrition

Additional orders: _____

D — DOCUMENTATION OF DISCUSSION

Discussed with:

☐ Patient ☐ Court-appointed Guardian
☐ Patient Advocate (DPOAH) ☐ Other Authorized Representative (specify): _____

Patient Goals:

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

My signature below indicates to the best of my knowledge that the orders are consistent with the patient's medical condition and goals of care.

Signature (mandatory)	Phone Number
Name (print/type)	Date (mm/dd/yyyy)

COMPLETE BELOW IF SIGNED BY NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

Name of Physician of contract:	Physician Phone Number:

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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

Pilot version 8/13/12

A note about using these tools…

Documents are only as good as the process of planning!

- If the person planning does not understand, reflect on, or discuss their choices/options adequately, the plan has a high probability of failure.
- ACP success is directly tied to the quality of the planning *process*.

Relevant Laws

History – Where it all Started

Karen Ann Quinlan --**Started "Right to Die" issue**

1975 (age 21) went into coma after party in New Jersey
On ventilator: father to court against hospital --- removed 1976
Died 1985 pneumonia as she continued on feeding tube

Nancy Cruzan -- **Ordinary care (food) versus extra-ordinary treatments**

1983 (age 25) car accident in Missouri
Feeding tube only and remained in persistent vegetative state
1987 Family fight to remove tube feeding---7 years court litigations
Died 1990 after it was removed

Terri Schiavo -- **Family battle over life-sustaining treatment**

1990 (age 26) cardiac arrest, CPR: irreversible persistent vegetative state
Husband & parents severely disagree on tube feeding
1998 first court: 14 FL state appeals, 5 federal suits, political
Died 2005 after tube feeding removed

Jahni McMath: 2013- current

Federal Law

Patient Self-Determination Act effective **1991**

3 Core Patient Rights:

1- Facilitate own healthcare decisions

2- To accept or refuse medical treatment

3- Right to make an advance health care directive

Federal Right to Refuse Medical Treatment

- Competent adults have the right to refuse medical/surgical treatment at any time, *even if that treatment is necessary to sustain life.*
- This right continues even if the person becomes incapable. (it is durable)
- The most that a state can require is "clear & convincing" evidence of the adult's choices.
- The right to refuse life-sustaining treatment does not depend on the pt's life expectancy or being "terminally ill".

Michigan Law

1990 Michigan Durable Power of Attorney for Healthcare

- Mechanism to appoint a Patient Advocate via the Durable Power of Attorney for Healthcare
- Requires healthcare organizations to inform patients of their right to complete this document
- Role of Patient Advocate: to make medical decisions on behalf of an individual who does not have medical decision-making capacity
- Patient Advocate must accept this role by signing an acceptance form before they are activated
- Role must be activated by 2 Doctors or a Doctor and a psychologist
- Can withhold or withdraw treatment that would allow the patient to die only if patient has expressed authorization in a clear and convincing manner and acknowledges that he/she is aware death will occur if designation is followed.

Duties of the Patient Advocate

- Limited to legally acceptable options.
- *Shall act consistent with the patient's best interests*. "The known desire of the patient, expressed or evidenced while the pt is able to participate in medical treatment decisions are presumed to be in the pt's best interests."
- Can withhold or withdraw treatment that would allow the patient to die only if patient has expressed authorization in a clear and convincing manner and acknowledges that he/she is aware death will occur if designation is followed.
- A person may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate intent to revoke.

Best interest

The "best interest" of a patient balances the following factors:

- Whether the ward ever expressed any view regarding life-sustaining treatment.
- The wishes of the family.
- An independent medical opinion.
- The recommendation, if any, of a bioethics committee.
- The chances of physical recovery.
- The chances of mental recovery.
- The likelihood of physical, psychological, or emotional injury as a result of providing or not providing treatment.
- The likelihood and duration of survival without treatment.
- The physical effects of prolonged treatment.

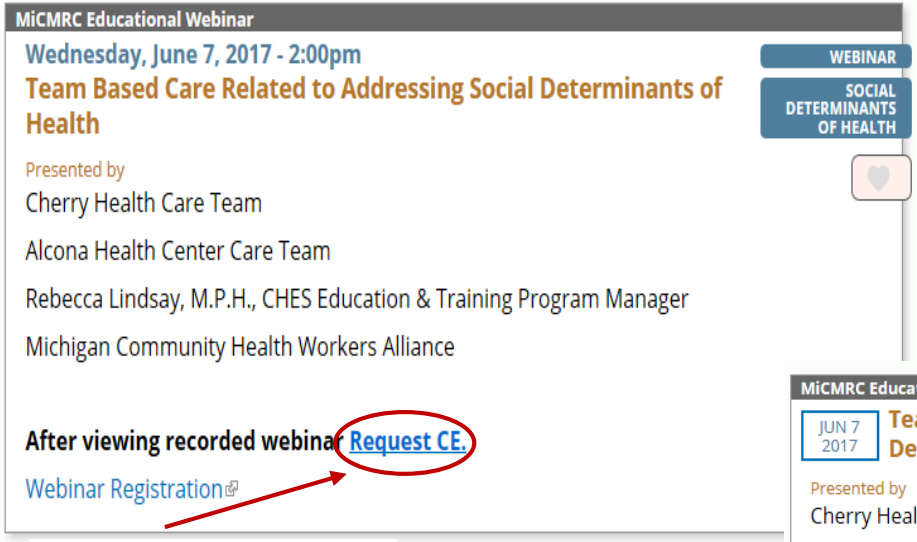
In absence of a Patient Advocate

- Who can make decisions?
  - Court-appointed Guardians: act in best known interest of the Patient
  - Other family as per organizational policy
    - Michigan does not have a specific Family Consent law

Questions

cstramecki@honoringhealthcarechoicesmi.org

Resources: www.ACPmich.org



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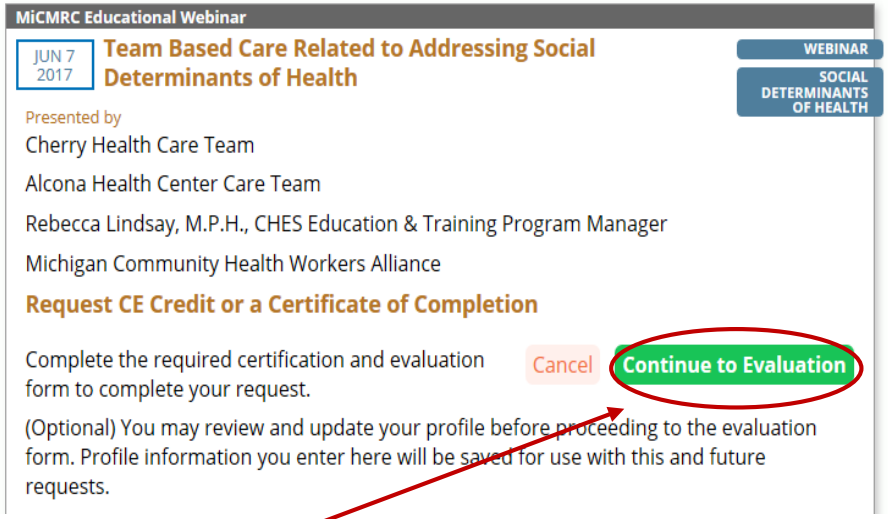

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