The Most Important Conversation: Tools and Techniques for Advance Health Care Planning

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NLRC

Providing Legal Support to the Aging Advocacy Network

- http://www.nlrc.aoa.gov/
- Collaboration developed by the Administration for Community Living/ Administration on Aging between the National Consumer Law Center, National Senior Citizens Law Center, American Bar Association Commission on Law and Aging, Center for Elder Rights Advocacy, and the Center for Social Gerontology
- See upcoming trainings, conferences, and webinars
- Request a training
- Request consulting
- Request technical assistance
- Access articles and resources

Presenter – David Godfrey

- Is a senior attorney at the ABA Commission on Law and Aging.
- He is responsible for the ABA's role in the Administration on Aging funded National Legal Resource Center.
- Prior to joining the Commission he was responsible for elder law programming at Access to Justice Foundation in Kentucky.

Defending Liberty
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The Most Important Conversation: Tools and Techniques for Advance Health Care Planning

David Godfrey
ABA Commission on Law and Aging

To be effective

- Advance Health Care Planning Requires

Goal of Advance Care Planning– Autonomy and Control

- Self direction
- Independent decisions
- Consultation / participation in all decision making
- Carefully select surrogates
- Advance care planning = meaningful guidelines for making unpredictable decisions

Landscape of Health Decisions Law Today

1. Default Surrogate Laws
2. Health Care Advance Directives
   - Living Wills
   - Specialized Advance Directives (mental health)
   - Health Care DPAs
3. Out-of-Hospital DNR Laws
4. Organ Donation Laws
5. Guardianship Laws
6. Physician Orders for Life-Sustaining Treatment (POLST/MOLST/POST)
7. Physician Aid in Dying

Poll Question #1

- Do you have an advance health care directive?
- A: Yes
- B: No

Default Health Care Decision Maker Laws

- Range/Priority of Surrogates
- Scope of Decision Making Authority
- Triggers/Pre-conditions
- How Disagreements are Handled
- *Close Friend and Un-befriended* Patient

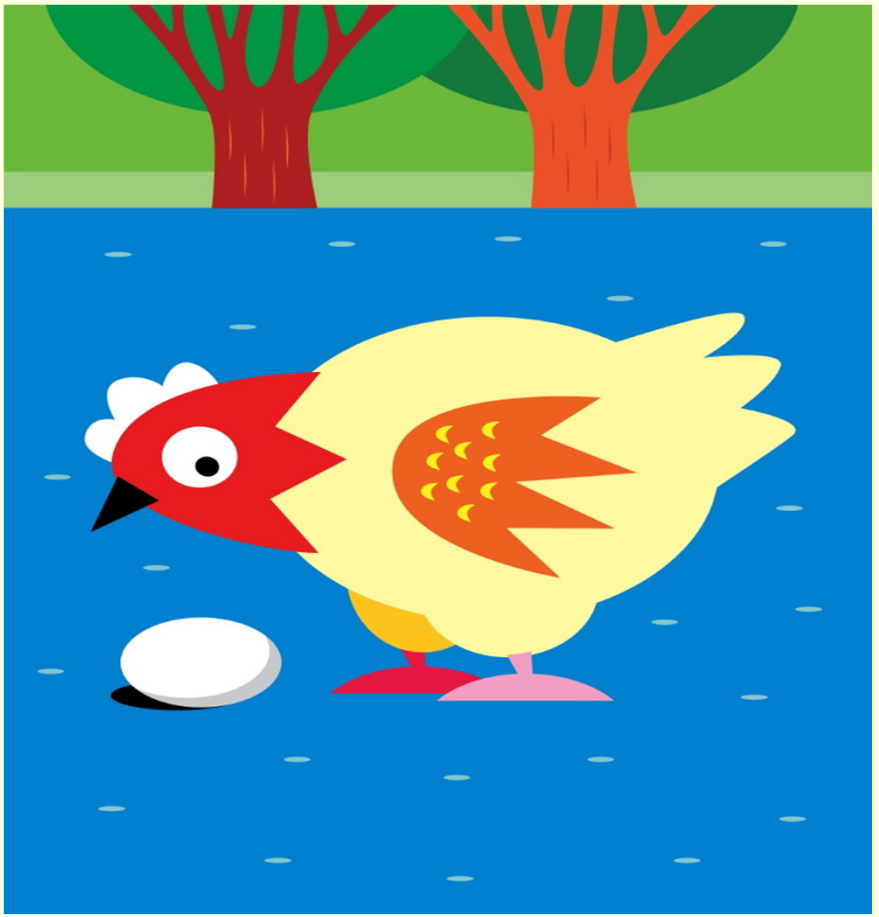
- Summary chart:
- http://www.americanbar.org/content/dam/aba/migrated/aging/PublicDocuments/famcon_2009.authcheckdam.pdf

Poll Question #2

- Who is your default health care decision maker, under the laws of your state?
- Spouse
- Parents
- Adult Children
- Other or don't know?

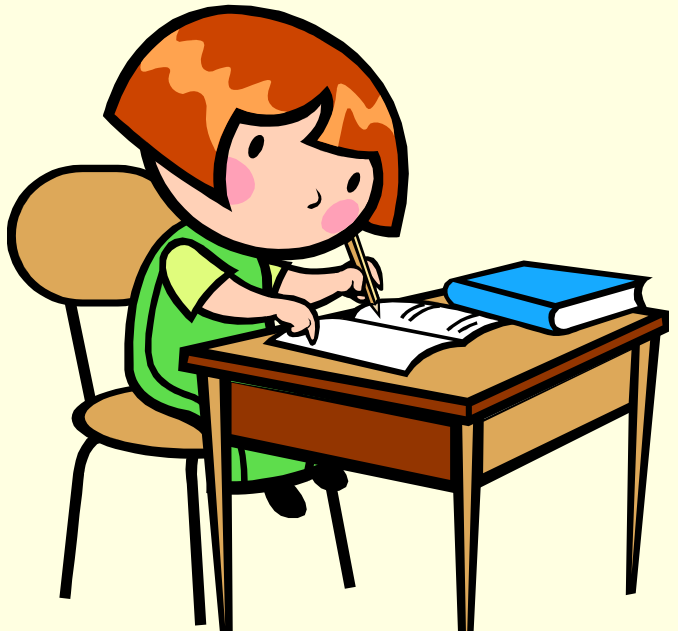
What comes first?

- Thoughtful consideration of beliefs, values, wishes
- Conversation
- Documents



Written Advance Directives

- Living wills
- Specialized advance directives
- DNR
- Durable Power of Attorney for Health Care



Poll Question #3

- Ms Ellie has been diagnosed with dementia, can she engage in advance health care planning?

- Yes
- No
- Maybe

Capacity is a prerequisite

- Ability to make and communicate informed decisions, about the issue under consideration
- Understand risks and benefits
- Make an informed choice

- If in doubt, ask for a professional evaluation

Living Will

- Instructions on life prolonging care at end of life
- Mostly statutory forms
- Focus is on end of life – life prolonging care
- Replacing or supplementing life sustaining function
- Tube Feeding (should be specific - Cruzan)
- Can include more depending on document

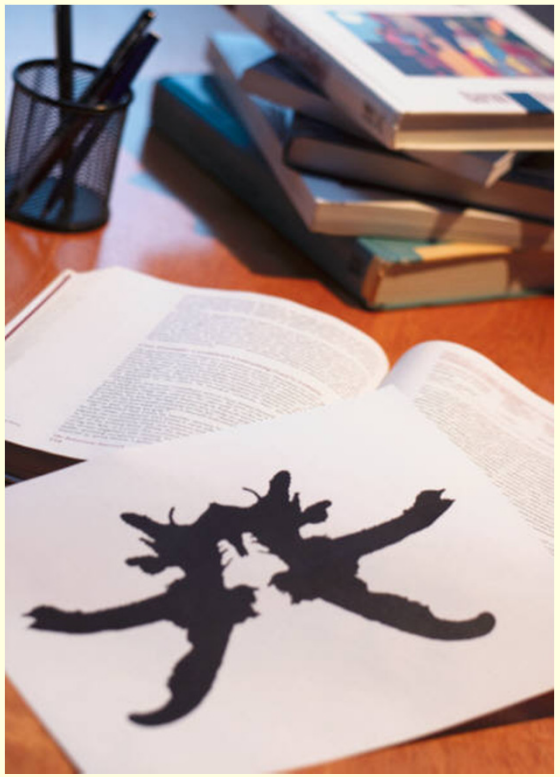
Living Will

- **Strengths**
- Standard available form
- Recognized by HC providers
- Establishes signing formalities
- May or may not name a surrogate

- **Weaknesses**
- Focus on end of life issues
- Forms can be confusing
- Limited directions / unpredictable needs
- Even if broader, tend to be interpreted as end of life
- Lack of conversation

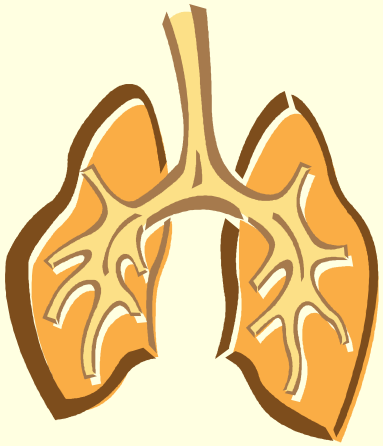
Specialized Advance Directives

- Advance Directives for Mental Health Care
- Custom or Standard form
- Very issue specific
- Narrow focus
- Hard to predict needs



DNR

- Limited
- Community
- Institutional
- Supplement or restart heart beat or breathing



Durable Power of Attorney For Health Care

- Names a health care decision maker
- Can (should) name successors
- Can be custom drafted and personalized

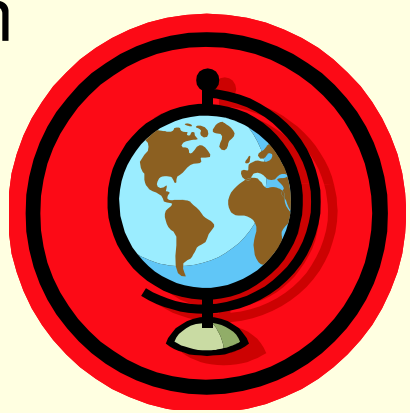
Multi State Form

- **Giving Someone a Power of Attorney**
- **For Your Health Care**
- A Guide with an Easy-to-Use, Legal Form for All Adults

- http://www.americanbar.org/groups/law_aging/resources/health_care_decision_making/power_atty_guide_and_form_2011.html

Where does it not work

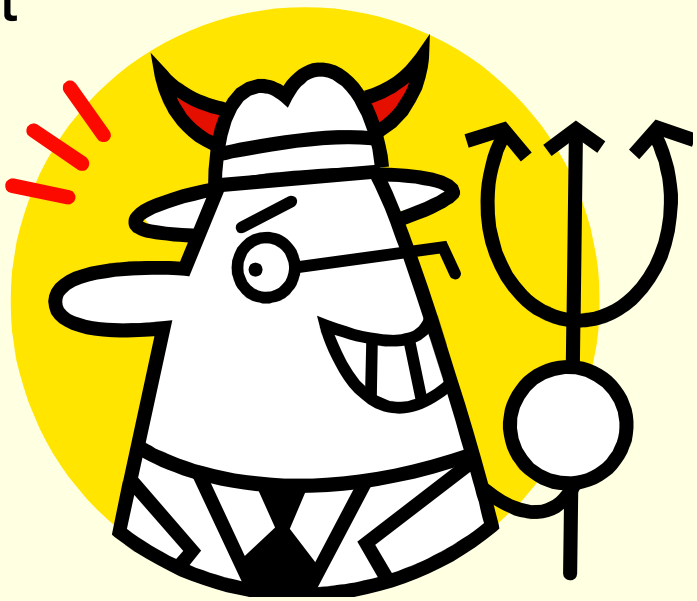
- Some states do not permit people to use a universal form. You cannot use this form in:
  - Indiana
  - New Hampshire
  - Ohio
  - Texas
  - Wisconsin



- Some states have special requirements for witnesses in certain care facilities. Do not use this form for a person who lives in a nursing home or any other care facility in:
  - California
  - Connecticut
  - Delaware
  - New York
  - Vermont

Poll #4

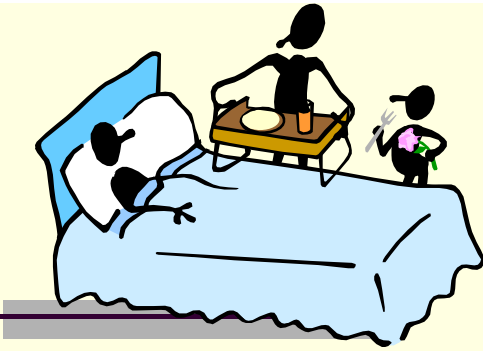
- What is a bad reason to name someone as your health care agent?
- Agent has to be my spouse
- Has to be my oldest child
- Would be upset if I didn't
- All of the above.



Step One: Select Agents

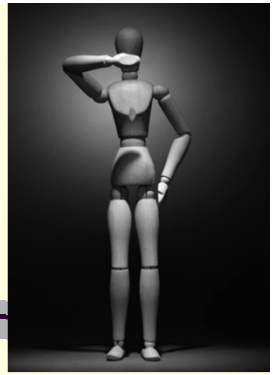
- **Think carefully about the person you choose to be your health care agent.**
- Your *health care agent* — or *agent*, for short — will have the authority to make life and death decisions for you according to your wishes.
- Make sure that the person you pick is willing to be your agent.
- Primary
- Back-up

Who to select as an agent?



- **Choose someone who will talk with you now about your wishes, who will understand what you want and your priorities about health care, and who will do as you ask faithfully when the time comes.**
- **Choose someone who lives near you or could travel to be with you**
- **Choose someone you trust with your life**
- **Choose someone who can handle conflicting opinions from family members, friends, and medical personnel**
- **Choose someone who can be a strong advocate for you if a doctor or institution is unresponsive**

Who can not be an agent



- DO NOT choose your health care providers or the owner or operator of a health or residential care facility that is currently serving you.
- DO NOT choose a spouse, employee, or spouse of an employee of your health care providers.
- DO NOT choose anyone who professionally evaluates your capacity to make decisions.
- DO NOT choose anyone who works for a government agency that is financially responsible for your care (unless that person is a blood relative).
- DO NOT choose anyone that a court has already appointed to be your guardian or conservator.
- DO NOT choose anyone who already serves as a health care agent for 10 or more people.

Step Two: What directions do you want to provide

- **Think about what guidance you want to give your health care agent in making treatment decisions for you.**
- **Then talk about your decisions.**
  - What you want is very important
  - Your agent must try to make decisions the way you would.
- **Have a real conversation with your agent and with anyone else who could be involved in your care if you were seriously ill.**
- This is not easy to do, so it is best to use resources to sharpen your thinking and to help guide you through the conversation.

Care Planning Guides

- ***Consumer's Tool Kit for Health Care Advance Planning,*** by the ABA Commission on Law and Aging.

  Go to: www.Ambar.org/AgingToolkit

- ***Caring Conversations Workbook*****,** *published by the Center for Practical Bioethics. Go to:* www.practicalbioethics.org/cpb.aspx?pgID=986

- ***Advance Care Planning Conversation Guide***, plus other resources from the Coalition for Compassionate Care of California. Go to: http://www.coalitionccc.org/advance-healthplanning.php

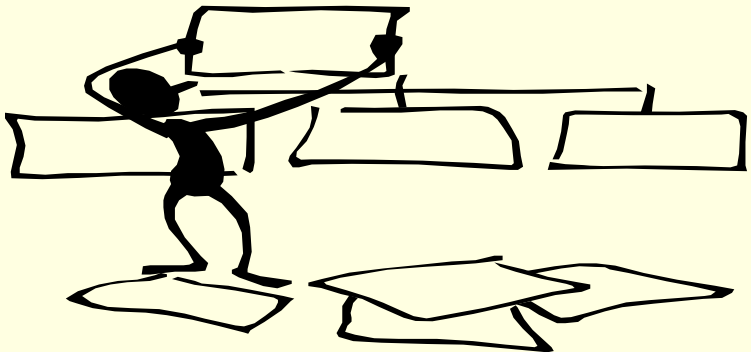
- Five Wishes, http://www.agingwithdignity.org/forms/5wishes.pdf

Step Three:

- **Fill out the form and follow the instructions for signing it in the presence of 2 witnesses.**
- Although this guide gives you space to add anything that is really important to you, it is better to use one of the help guides to fully talk about your wishes and goals.

If you change your mind:

- **You need to cancel or update…**
- If you want to cancel or change your document, the rules for how to do that depend on where you live. The safest way to do it — which will be valid everywhere — is to complete and sign a new form, destroy all copies of the old form that you have, and tell anyone else who has a copy that you've revoked the old form.



Then What?

- Copies to
- Agent, health care providers, other family
- Talk to other family members and loved ones about your wishes
- Make sure everyone knows who the agent and back up are
- Assure that the documents are available when needed
- Update the documents
- Enjoy Life

Poll #5

- How long would it take you to put your hands on a copy of your advance health care directive?
- Don’t have one
- Less than 60 minutes
- 1-4 hours
- 5-24 hours

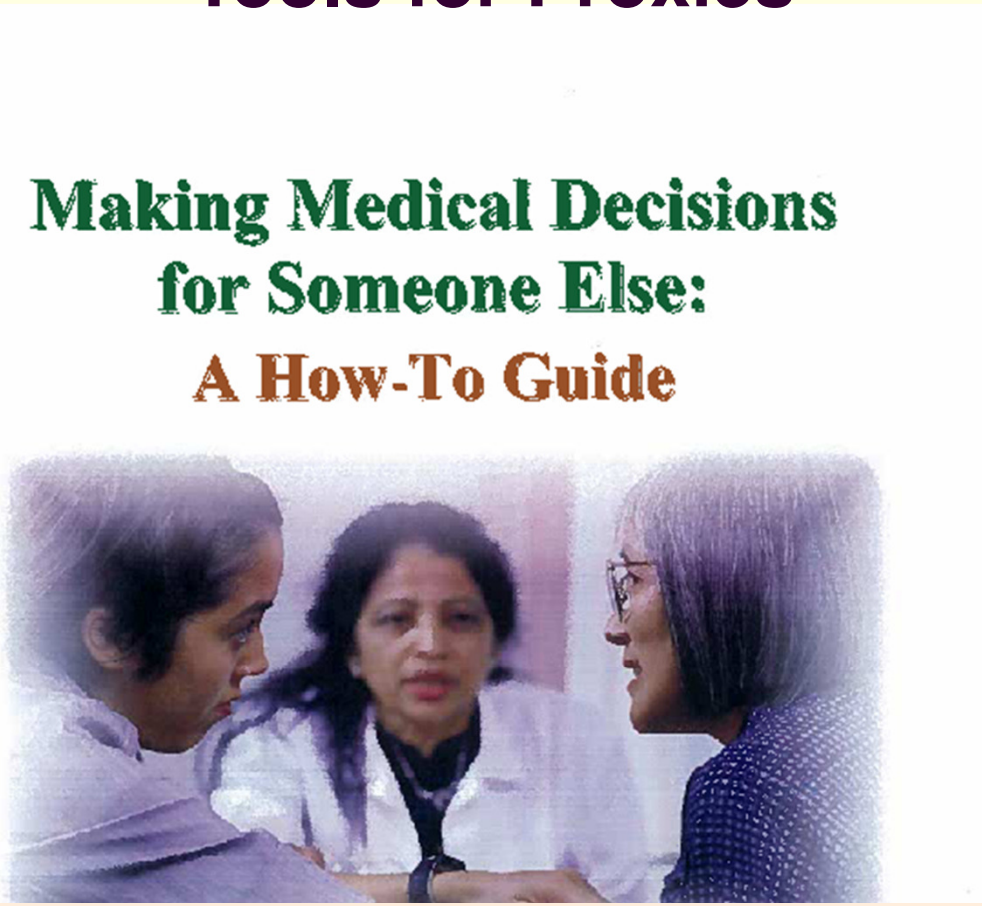
Communications Approach
"Advance Care Planning"

- **Less focus on legal formalities**
- **Legal focus primarily on naming a proxy**
- **ACP is discussion focused (with proxy, family, health care providers)**
- **More broadly focused on values, spiritual questions, family matters**
- **Less treatment focused**

Self-Help Workbook Examples…

- **Finding Your Way: A Guide for End-of-Life Medical Decisions, by the Center for Healthcare Decisions** Sacramento Healthcare Decisions
- **Caring Conversations**, The Center for Practical Bioethics
- ***Good to Go* Toolkit and Resource Guide**, Compassion and Choices
- **Thinking Ahead – My Way, My Choice, My Life at the End,** California Dept. of Developmental Services
- **Consumer's Tool Kit for Health Care Advance Planning** ABA Commission on Law and Aging
- **MyDirectives.com** - Free, interactive web-based program and registry

Tools for Proxies



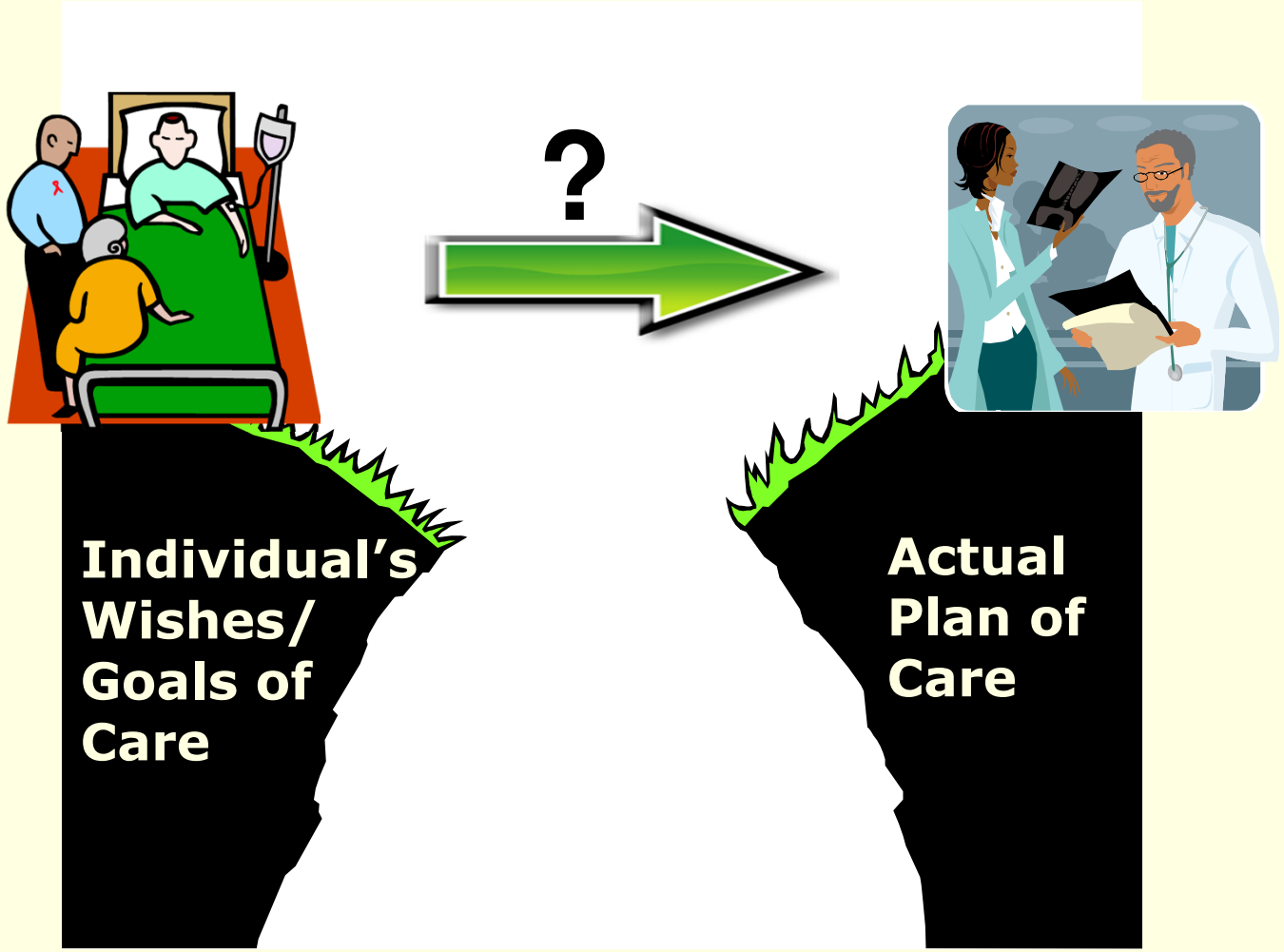
www.americanbar.org/groups/law_aging/resources/health_care_decision_making/Proxyguide.html

Key Questions for Any Major Treatment Decision

1. Will treatment make a difference?
2. Do burdens of treatment outweigh benefits?
3. Is there hope for recovery?
   - If so, what will life be like afterward?
4. What does the patient value?
   - What is the goal of care?

Adapted from Pat Bomba, CompassionAndSupport.org

The Big Gap in the ACP Process

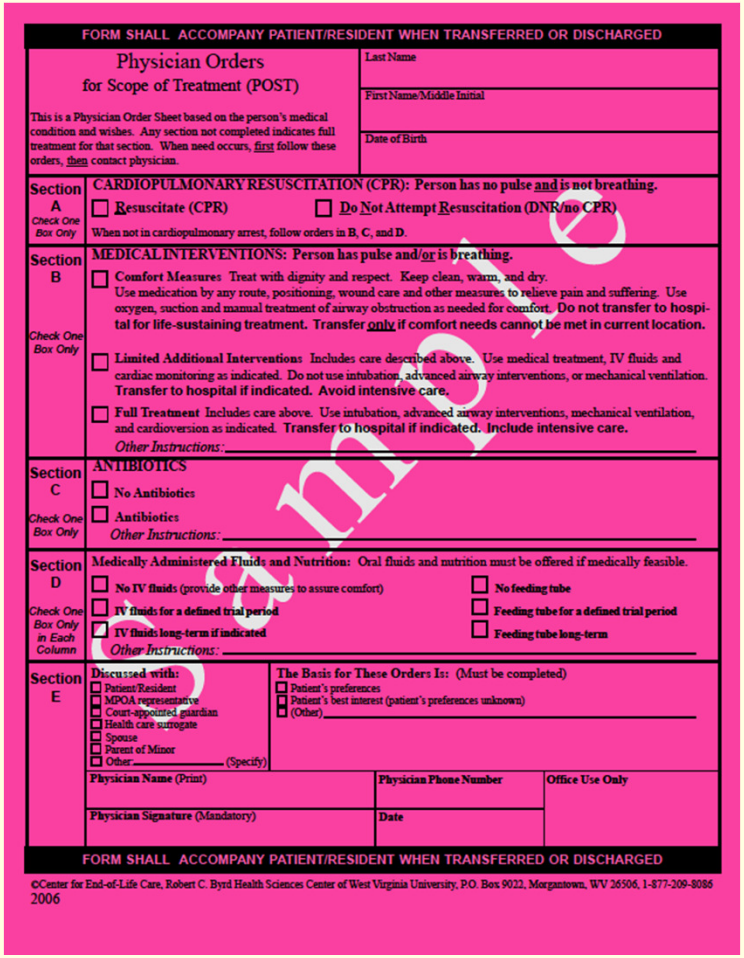


Engage Health Care Providers

- Provide Copies of all Advance Directives
  - Where are the documents (scanned on your phone?)
- Schedule conversations with medical staff
  - Repeat with each new provider
  - Even if you have to pay out of pocket
- Actively Participate in Care Planning Conferences for nursing home patients

Beyond
Advance Directives and Care Planning

- Physicians Orders on life sustaining care



FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Last Name

First Name/Middle Initial

Date of Birth

Section A — Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ Resuscitate (CPR) ☐ Do Not Attempt Resuscitation (DNR/no CPR)

When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B — Check One Box Only

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

☐ **Comfort Measures** Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.

☐ **Full Treatment** Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.

Other Instructions:

Section C — Check One Box Only

ANTIBIOTICS

☐ No Antibiotics

☐ Antibiotics

Other Instructions:

Section D — Check One Box Only in Each Column

Medically Administered Fluids and Nutrition: Oral fluids and nutrition must be offered if medically feasible.

☐ No IV fluids (provide other measures to assure comfort)

☐ IV fluids for a defined trial period

☐ IV fluids long-term if indicated

☐ No feeding tube

☐ Feeding tube for a defined trial period

☐ Feeding tube long-term

Other Instructions:

Section E

Discussed with:
☐ Patient/Resident
☐ MPOA representative
☐ Court-appointed guardian
☐ Health care surrogate
☐ Spouse
☐ Parent of Minor
☐ Other: _____ (Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient's preferences unknown)
☐ (Other) _____

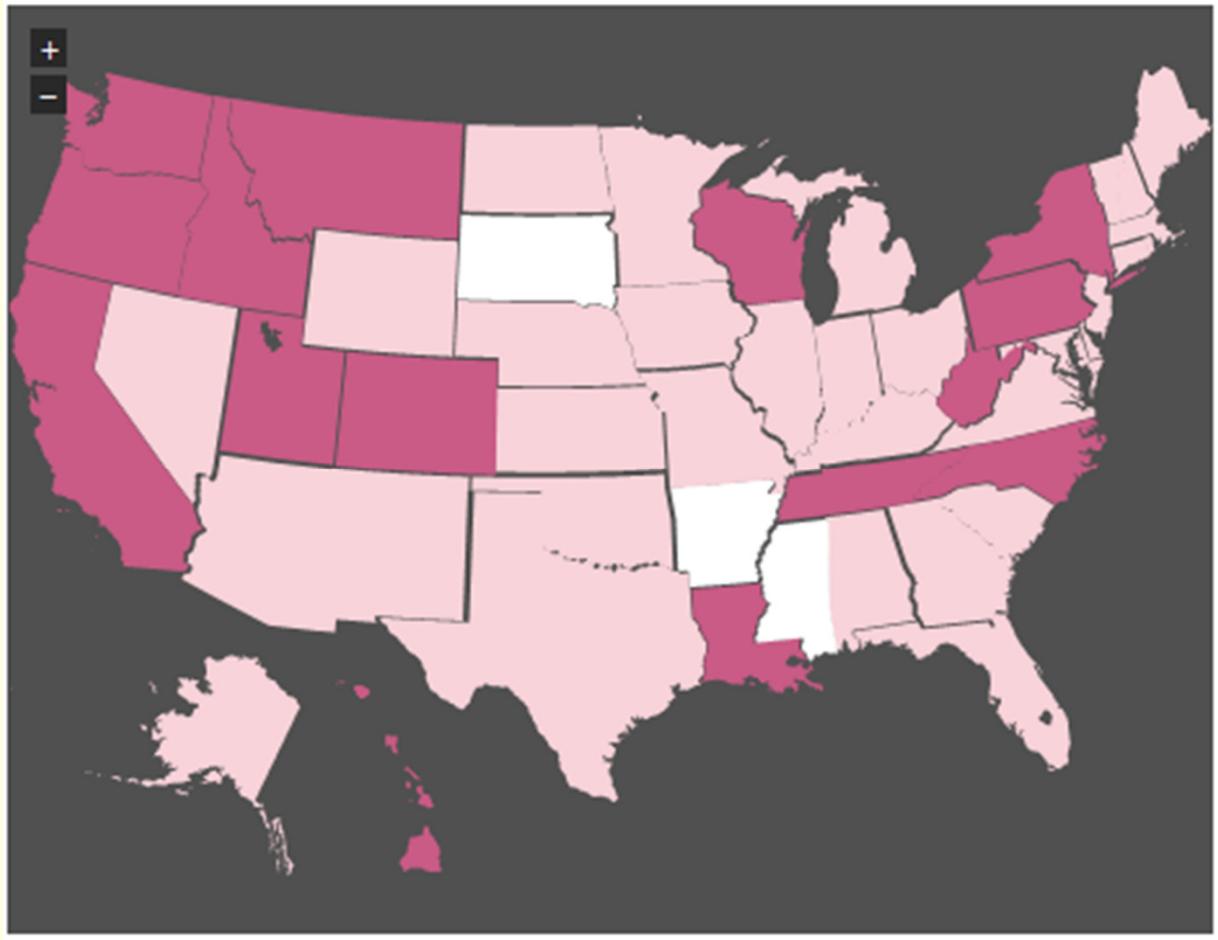
Physician Name (Print)	Physician Phone Number	Office Use Only
Physician Signature (Mandatory)	Date	

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

The POLST Paradigm

- Additional, systemic step to bridge gap between patient's goals/preferences and implementation of an actual plan of care.
- Four actions required:
  1. **Discussion: Find out patient's goals/wishes re: CPR, care goals (comfort vs. treatment), N&H, etc.**
  2. **Translate into doctors orders on visually distinct medical file cover sheet.**
  3. **Ensure order set follows patient across care settings.**
  4. **Review**
- POLST is not a form, it's a Process.

www.POLST.org



As of April 1 2013

What are the primary differences between an Advance Directive and a POLST form?

ADVANCE DIRECTIVE

- For anyone 18 and older
- Provides instructions for **future** treatment
- Appoints a Health Care Representative
- Does not guide Emergency Medical Personnel
- Guides inpatient treatment decisions when made available

POLST

- For persons with advanced illness – at any age
- Provides medical orders for **current** treatment
- Guides actions by Emergency Medical Personnel when made available
- Guides inpatient treatment decisions when made available

Questions?

Thank You!

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