Respecting Choices® in the PA-LTC Setting

MiMDA Annual Education Conference
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September 17, 2016
Objectives

- Understand Advance Care Planning (ACP) in the Post Acute/Long Term Care Setting
- Understand the value of palliative care and Hospice as part of patient centered care
- Understanding ACP, apply conceptual framework in a case-based approach in the PA/LTC setting
- Create strategies of daily practice incorporating ACP as part of good health care in the PA/LTC setting
Definitions
End of Life Care (EoLC)

- Health care of those with a chronic condition or terminal illness that has become advanced, progressive and incurable
End of Life Care (EoLC)

- Encompasses:
  - Palliative care
  - Patient’s rights for self determination
  - Ethics and efficacy of extraordinary or hazardous medical interventions
  - Rationing and allocation of resources
- Primarily subject to patient autonomy
Palliative Care

- Palliative Care is a conceptual way of managing chronic disease with an emphasis on pain or symptom control.
- That concept respects choices that an individual might make regarding the degree of treatment or testing received.
- The over-reaching goal of palliative care is to maintain quality of life over quantity of life.
- It does so in a way that the patient, or their advocate, is actively involved in choice with decisions.
Hospice Care

- Care designed to give support to people in the final phase of a terminal illness
- Typically when life expectancy is less than six months
- Focus on comfort and quality
- Usually home based
- Team approach to care, including:
  - Physician
  - Nurse practitioner
  - Hospice nurse
  - Social worker
  - Pastoral care
  - Music or massage therapy
Advance Care Planning

- Involves taking the time to learn about end-of-life care options and services before a health crisis. Advanced or pre-planning involves making choices based on a person's priorities, beliefs and values and sharing his or her wishes in writing through an advance directive.

- *Advance Care Planning* can and should include discussions and document plans that address the "ifs" and ambiguities of living with chronic or terminal illness.
Advance Directive

- An Advance Directive is a **written document** in which you specify what type of medical care you want in the future, or who you want to make decisions for you, should you lose the ability to make decisions for yourself.
QUALITY AGE CURVES
Sudden death

AGE

QUALITY
Old age
Congestive Heart Failure

![Graph showing quality over age](image)
Case Study
Case study 1: A Bad Ending
Richard R.

![Graph showing the relationship between age and quality](Quality_Age.png)
What contributed to this being a bad death?

- Richard did not have an Advance Directive
What contributed to this being a bad death?

- Richard did not have an Advance Directive
- Richard did not have a Durable Power of Attorney for Health Care
Durable Power of Attorney for Health Care

- A durable power of attorney for health care is a **document** in which you appoint another individual to make medical treatment and related personal care decisions for you.

- To be valid, this declaration must be in writing, signed by the individual and witnessed by two adults.

- Cannot be family member, physician, your proposed patient advocate, or an employee of a health facility or program where you are a patient.
What contributed to this being a bad death?

- Richard did not have an Advance Directive

- Richard did not have a Durable Power of Attorney for Health Care

- Richard did not have a Living Will
A living will is a document in which you inform doctors, family members and others what type of medical care you wish to receive should you become terminally ill or permanently unconscious. It only goes into effect if you are unable to make or communicate decisions about your care.
Living Will

- How is a living will different from a durable power of attorney for health care?
  - Although there can be overlap, the focus of a durable power is on who makes the decision; the focus of a living will is on what the decision should be.

- A living will is limited to care during terminal illness or permanent unconsciousness, while a patient advocate may also have authority in circumstances of temporary disability.

- A durable power of attorney for health care may be more flexible because your patient advocate can respond to unexpected circumstances, but a living will might be honored without the presence of a third person making the actual decision.
What contributed to this being a bad death?

- Richard did not have an Advanced Directive
- Richard did not have a Durable Power of Attorney for Health Care
- Richard did not have a Living Will
- Richard’s children, without directives, chose a path of doing everything for him, until there was nothing left to do
Definition: Advance Care Planning

ACP is a process of planning for future medical decisions. To be effective, this process includes:

**Reflection** on goals, values, and beliefs (including cultural, religious, spiritual, and personal)

**Understanding** of possible future situations and decisions

**Discussion** of these reflections and decisions with those who might need to carry out the plan
Honor Informed Healthcare Decisions
Create an effective plan that includes

■ The selection of a well-prepared healthcare advocate when possible
■ Specific instructions that reflect informed decisions geared to a person’s state of health

Make plan available to healthcare providers and treating physician to convert patient decisions to medical orders when necessary
Respecting Choices®

From…
An Advance Care Planning System that Works

To…
A System for Person-Centered Decision Making that Transforms Healthcare
Respecting Choices®

Four Key Elements for Success

1. Systems Design
2. ACP facilitation skills education and training
3. Community education and engagement
4. Quality Improvement
Respecting Choices®

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1. Systems Design
2. ACP facilitation skills education and training
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Respecting Choices®

Facilitated discussions

- Not a “one size fits all” discussion
- Must be individualized to patient readiness and stage of health
- Requires ACP facilitation skills to address stage of planning
First Steps
ACP: Create DPOAH and consider when a serious neurological injury would change goals of treatment.

Healthy adults between ages 55 and 65.

Next Steps
ACP: Determine what goals of treatment should be followed if/when complications result in “bad” outcomes.

Adults with progressive, life-limiting illness, suffering frequent complications.

Last Steps
ACP: Establish a specific plan of care expressed in medical orders using the POLST paradigm.

Adults whom it would not be a surprise if they died in the next 12 months.
Respecting Choices®

ACP facilitation skills education and training

Staged approach to Advance Care Planning

■ First Steps
  ■ Designate an advocate

■ Next Steps
  ■ Disease Specific ACP

■ Last Steps
  ■ Facilitate a discussion to convert to Last Steps Treatment Preferences
  ■ Physician’s Orders for Life Sustaining Treatment (POLST)
  ■ MIPOST (draft)
Certified Facilitators

- To talk with patients
- To talk with patients and their advocate
- To help communicate wishes with a written plan that is clear
Respecting Choices® Last Steps Conversation

Evidence-based Motivational Interview Format

Asking Patient and their advocate (if present):

- Understanding of what patient (advocate) understands about current medical condition
  - Questions recorded to ask physician
- Asking “living well” questions
- Summarizing
- Transition to specific medical interventions Using Decision-making Framework
Respecting Choices® Decision-making Framework

Explore understanding of proposed treatment/intervention
Explore understanding of benefits and burdens
  • Use Decision Aids as appropriate
Explore goals for treatment
Explore fears and concerns
Decision Aid Example: Success of CPR

In the nursing home

• <3% survive

• Of those that survive, those that have good neurologic function or minimal deficits
  • Age 70-85 is 2%
  • > 85 is 0.8%
Respecting Choices®

Facilitated Last Steps conversation results in documenting treatment preferences options:

- Physicians Orders for Scope of Treatment (POLST)
- Last Steps Treatment Preference Form
- MiPOST
- All currently used as a communication tool in MI
# My Treatment Preferences (Goals of Care)

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Specific Instructions to my Patient Advocate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name/Middle Initial:</td>
<td>When I am not able to decide or speak for myself, the following are my specific preferences and values concerning my health care.</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Gender: (circle)</td>
</tr>
<tr>
<td>Last 4 SSN:</td>
<td>M</td>
</tr>
</tbody>
</table>

## Contact Information

<table>
<thead>
<tr>
<th>Address:</th>
<th>Phone Number:</th>
<th>Alternate Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td>State:</td>
<td>Zip Code:</td>
</tr>
</tbody>
</table>

### A CARDIOPULMONARY RESUSCITATION (CPR): If my heart or breathing stops.

- [ ] Attempt Resuscitation/CPR
- [ ] DO NOT Attempt Resuscitation/CPR (DNR/No CPR)

(Note: If “Attempt Resuscitation/CPR” is checked in Section A, “Advanced Interventions” must also be checked in Section B.)

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

All patients will receive comfort measures.

- [ ] Advanced Interventions: Use intubation, advanced invasive airway interventions, mechanical ventilation, cardiovascular 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 preferences:

- 
- 
- 

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

- [ ] Long-term artificial nutrition

- [ ] Defined trial period of artificial nutrition

- [ ] No artificial nutrition

Additional preferences:

- 
- 
- 
**DOCUMENTATION OF DISCUSSION**

<table>
<thead>
<tr>
<th>Patient Last Name:</th>
<th>Patient First Name:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Discussed with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Patient</td>
</tr>
<tr>
<td>□ Patient Advocate (DPOAH)</td>
</tr>
<tr>
<td>□ Court-appointed Guardian</td>
</tr>
<tr>
<td>□ Other Authorized Representative (specify):</td>
</tr>
</tbody>
</table>

I am providing these instructions of my own free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind. These are my preferences and goals expressed and affirmed on the date below.

<table>
<thead>
<tr>
<th>My SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>My signature indicates that the above treatment preferences are consistent with my goals of care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature (required):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name (print):</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Time:</th>
</tr>
</thead>
</table>

**COMPLETE IF patient has lost decision-making capacity (Patient Advocate/Guardian)**

<table>
<thead>
<tr>
<th>Signature:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Name (print):</th>
<th>Date:</th>
</tr>
</thead>
</table>

The patient and/or the patient’s advocate may revoke these treatment preferences at any time.

**CERTIFIED FACILITATOR assisting with completion of Treatment Preferences Form**

<table>
<thead>
<tr>
<th>Name (print):</th>
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<table>
<thead>
<tr>
<th>Date:</th>
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</table>
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.

A

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

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

(NOTE: If “Attempt Resuscitation/CPR” is checked in Section A, “Advanced Interventions” must also be checked in Section B.)

B

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

ALL patients will receive comfort measures.

☐ Advanced Interventions: Use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion and other advanced 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.

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

Additional orders: ____________________________

D

DOCUMENTATION OF DISCUSSION

Discussed with:
☐ Patient
☐ Patient Advocate (POA/N)  ☐ Court-appointed Guardian
☐ 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)       Time

COMPLETE BELOW IF SIGNED BY NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

Name of Physician of contract:

Physician Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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

V. 7.16.13
**SIGNATURES**

<table>
<thead>
<tr>
<th>Patient Last Name:</th>
<th>Patient First Name:</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

**E**

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

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Signature</th>
<th>Date (mm/dd/yyyy)</th>
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<table>
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<th>Address</th>
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<th>Alternate Phone Number</th>
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</table>

The patient and/or the patient’s authorized representative may revoke these directions at any time.

**Witness (1) Signature:**

**Witness (2) Signature:**

**HEALTHCARE PROVIDERS ASSISTING WITH COMPLETION OF POST FORM**

<table>
<thead>
<tr>
<th>Preparer’s Name (print)</th>
<th>Preparer’s Signature</th>
<th>Date (mm/dd/yyyy)</th>
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**HOW TO CHANGE THIS FORM**

The POST form should be reviewed periodically and if:

- The patient/resident is transferred from one care setting or care level to another;
- There is a substantial change in patient/resident health status such as:
  - Improved Condition
  - Advanced Progressive Illness
  - Permanent Unconsciousness
  - Close to death
  - Extraordinary Suffering
- The patient’s/resident’s treatment decisions change.

If this form is revoked, write “VOID” on both sides in large letters, then sign and initial the form. After voiding the form, a new form may be completed. **If no new form is completed, full treatment and resuscitation shall be provided.**

**REVIEW OF THIS POST FORM**

<table>
<thead>
<tr>
<th>Date</th>
<th>Reviewer Name</th>
<th>Location of Review</th>
<th>Outcome of Review</th>
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</thead>
<tbody>
<tr>
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<td>No change</td>
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<td>Form voided</td>
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<td>New Form completed</td>
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<td>No change</td>
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<td>Form voided</td>
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</tr>
</tbody>
</table>

**DIRECTIONS FOR HEALTH CARE PROFESSIONALS**

- POST must be completed by a healthcare professional based on patient decisions and medical indications.
- POST must be signed by a Physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility policy. OR
  - A Physician’s Assistant or Nurse Practitioner may sign the POST if working under the direction of a physician.
- Use of original forms is strongly encouraged. Photocopies, electronic forms, and faxes of signed POST form are valid.
- POST should be kept in a visible and accessible location.
- Healthcare providers should maintain a copy of the POST in the patient’s chart.

**SEND FORM WITH PERSON WHenever TRANSFERRED OR DISCHARGED**

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

V. 7.16.13
Last Steps Treatment Preferences

Follows the person as part of AD documentation

- Embedded in EHR (local)
- Uploaded into Great Lakes Health Connect (GLHC)
Respecting Choices® in PA-LTC: Sample Workflow

Person admitted to Subacute rehab post hospital
Provider considers the “Surprise Question” as part of each initial comprehensive visit
Refers/Orders a Last Steps® conversation with a certified facilitator
Outcome of conversation shared with the team and plan of care modified
Discharge orders include treatment preferences in the transition of care
Respecting Choices® in PA-LTC Challenges

Specifically in Post Acute/Transitions/SAR

- Too far downstream
- Short term stays
- Decision making capacity issues
- Transition of documents/documentation
Objectives

- Understand Advance Care Planning (ACP) in the Post Acute/Long Term Care Setting
- Understanding ACP, apply conceptual framework in a case-based approach in the PA/LTC setting
- Create strategies of daily practice incorporating ACP as part of good health care in the PA/LTC setting

Questions/Discussion
Why go through all this trouble?

- It’s the right thing to do
- It brings value to the work we do
Present and future components of PA/LTC Quality

- Readmission rates
- Participation with bundled care products
- Participation with ACO’s
Patient Centered Care

- Defined as:
  - Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions
    - Institute of Medicine (2001)