Advanced Care Planning Guidelines and Resources

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NPA PC/EOL Workgroup History

- **<2014**
  - Presentations Interest

- **2015**
  - 5 members PCC Survey Conference

- **2016**
  - 30 members Definitions Guidelines 10 Modules Conference

- **2017**
  - 60 Members Bereavement ACP Resource Table

- **2018**
  - 50 Members P.M. Boot Camp Conference
How to Access Resources

- NPA members
- NPA Website
  - Member Resources
  - Participant Care Resources

http://www.npaonline.org/member-resources/participant-care-resources
How to become a member

NPA Contact:
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Objectives

1. Increase understanding of the purpose and goals of the NPA PC/EOL workgroup.
2. Learn about advance care planning guidelines and resources available to PACE organizations.
3. Be able to access advance care planning guidelines and resources.
Overview

- Definitions
- Checklist
  - Background
  - Purpose
  - Meeting
  - Conversation
Advance Care Planning (ACP)

• ACP is making decisions about the care patients would want to receive if they become unable to speak for themselves. These are their decisions to make, regardless of what they choose for their care, and the decisions are based on their personal values, preferences, and discussions with their loved ones.
Chronic disease or functional decline

Advancing chronic illness

Multiple co-morbidities, with increasing frailty

Healthy and independent

Maintain & maximize health and independence

Death

Compassion, Support and Education along the Health-Illness Continuum

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• This is called different things in different states. Yet, regardless of the term, a POLST form is a medical order for the specific medical treatments a patient wants during a medical emergency. POLST forms are appropriate for individuals with chronic illness or advanced frailty near the end-of-life.
Medical Orders for Life-Sustaining Treatment (MOLST) Program

• Improve the quality of care people receive at the end of life:
  o effective communication of patient wishes
  o documentation of medical orders on a brightly colored pink form
  o promise by health care professionals to honor these wishes

• Complements the use of traditional advance directives.
Advance Directive (AD)

- This is called different things in different states (e.g., living will, health care power of attorney). Yet, regardless of the term, this describes a legal document patients use to provide guidance about what types of treatments they may want to receive in case of a future, unknown medical emergency. It also is where they say who can speak for them to make medical treatment decisions when they cannot speak for themselves (called a "surrogate"). All adults should have an advance directive.
Living Will

- Also called a directive to physicians or advance directive, is a document that lets people state their wishes for end-of-life medical care, in case they become unable to communicate their decisions. A living will is one type of advance directive.
## POLST/MOLST vs. Advance Directives

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Health Care Proxy / Living Will vs. MOLST

- **Health Care Proxy / Living Will:**
  - completed ahead of time
  - applies only when decision-making capacity is lost

- **MOLST:**
  - applies right now
  - not conditional on losing decision-making capacity
  - set of actionable medical orders
Medical Power of Attorney

• Also called Healthcare Power of Attorney, a Health Care **Power of Attorney** (HCPOA) is a legal document that allows an individual to designate another person to make medical decisions for him or her when he or she cannot make decisions for themselves.
The Advanced Care Planning Work Group recommends that PACE programs review these documents a minimum of every year and at any change in condition. Many programs review them every six months with the PACE participant’s biannual assessments.
Advance Care Planning Checklist

- Background
- Purpose
- Family Meeting
- Conversation
• Advance care planning (ACP) is a process that enables individuals to define goals and preferences for future medical treatment and care, to discuss these with family and healthcare providers, and to record and review preferences if appropriate. Individuals who have completed an advance directive are more likely to receive care that aligns with their preferences.
Checklist: Purpose

• to provide PACE organizations with guidance on how to have effective advance care planning discussions
Checklist: Purpose

- Advance care planning aims to prepare and to engage individuals to take a role in healthcare decision-making.
Checklist: Before Meeting

• Provide written material to participant

• Preparation for meeting:
  o Access participant’s decision-making capacity.
  o Current ACP documents
    • MPOA
    • Advance Directives
    • Current PACE Pathway

• The Surprise Question: “Would we be surprised if the participant were to die in the next year?”
Checklist: Before Meeting

Preparation for meeting:

- Medical history
- Understand the participant’s cultural and spiritual preferences and beliefs
- Understand the participant’s mental and emotional health history
Checklist: Frequency

- Annually. May consider every six months.
- With any change of condition.
- Physical, Functional, or Medical decline.
Checklist: Meeting

- **Purpose**: To create an ACP through thoughtful discussion, education, and collaboration.
- **Who**: Participants and family member. Provider and Social Worker. Other IDT representatives as appropriate.
- **Allotted time**: 60 minutes.
Checklist: Conversation

• Introduction of those in attendance

• Give an overview of the meeting:
  o Purpose
  o Goals
  o Expectations
  o Allotted time
Checklist: Conversation

• Ask participant and family if they understand the purpose and have any questions.

• Review current health status and functional ability (diagnosis, medications, etc.) and highlights of current plan of care.
Checklist: Conversation

• Discuss projected health status and functional status given current health status:
  o Ask the participant and/or family if this is something specific they would like to discuss.
  o Ask if they are interested in talking about your current and future health status?
    • If participant expresses unwillingness to have the discussion, then inquire further to understand his/her position.
Checklist: Conversation

• **Elicit general wishes and goals for:**
  - Health
  - Housing
  - Functional ability
  - Cognitive ability
  - “What are you hoping for or expecting over the next six months to a year?”
Checklist: Conversation

• Explanation and discussion of Advance Directive forms
  o **Purpose:** Describe why the participant is being asked these questions and how it will and will not be used.
Checklist: Conversation

• **CPR section:**
  - Examples of question to engage a participant in conversation:
    - What do you think CPR is?
    - Have you witnessed CPR?
    - What is your previous experience with CPR, if any?
    - What do you think happens?
    - What do you think the chances of survival?
Checklist: Conversation

• CPR section:
  o Give example of what actually happens during the administration of CPR.
  o Give examples of CPR in real world situations for the frail elderly population.
  o Discuss survival rates.
Checklist: Conversation

• **Medical Interventions sections:**
  - Describe in detail and relate choices to participants wishes and goals of care.
  - Discuss why or why not someone may choose between the types of treatment.
Checklist: Conversation

• **Medical Interventions sections:**
  
  o Give examples of how someone may want to limit the definitions or describe:
    
    • Full Treatment (PACE Longevity Pathway)- primary goal to prolong life by all medically effective means.
    
    • Selective treatment (PACE Functional Pathway)- goal to treat medical conditions with avoiding burdensome measures.
    
    • Comfort Treatment (PACE Comfort Pathway)- primary goal to maximize comfort.
    
    • End-of-Life Treatment (PACE End-of-Life Pathway)- primary goal is relief suffering and increase quality.
Artificially Administered Nutrition section:
  - Define artificial nutrition.
  - Give examples.
  - Include in discussion:
    - Limiting the definition to meet their wishes.
    - Length of time the participant may want to try an intervention before discontinuing it.
Checklist: Conversation

• **Explanation and discussion of Medical Power of Attorney Form** (aka-Health Care Proxy, Surrogate Decision Maker, etc.)
  - Explain the importance of this document.
  - Explain the importance of picking the person who you believe will follow your wishes.
  - Give real world examples.
Checklist: Conversation

- Explanation and discussion of Medial Power of Attorney Form (aka-Health Care Proxy, Surrogate Decision Maker, etc.):
  - Encourage the participant to have a discussion with their MPOA to express why they’ve made the decision.
  - If MPOA is present get verbal confirmation that they will follow the participant’s wishes.
  - Emphasize the importance of having these crucial conversations on an ongoing basis.
Checklist: Conversation

• Ending of conversation:
  o Give synopsis of conversation
  o Review decisions made
  o Have participant sign the document or documents
  o Explain the next steps in the process
  o Ask if there are any other questions
  o Emphasize the importance of having these crucial conversations on an ongoing basis.
Checklist: After Meeting

• Make copies of the documents for the participant.
• Documentation in the medical record.
• Communication of updated ACP to IDT.

• National POLST Paradigm
• NPA Advance Care Planning Taskforce Resource Recommendations
http://www.npaonline.org/member-resources/participant-care-resources
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