ADVANCE DIRECTIVES and Palliative Care

KUMC – AHEC webinar

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OBJECTIVES

List	• three ADVANCE DIRECTIVES
Discuss	• differences between the three Advance Directives
Identify	• How advance directives can help establish goals of care.

OBJECTIVES

Discover	• where to find statues for each type of adv. Dir.
Outline	• Ideas of implementation of Adv.Dir. into an organization.
Explain	• how advance directives can fit into Palliative Care.

WHAT IS ADVANCE CARE PLANNING?

WWW.NIA.NIH.GOV (HOW TO TALK TO PATIENTS)

- "A process of reflection and discussion preparing for future decisions about your medical care if you become seriously ill or unable to communicate your wishes."
- You should decide about the kind of care you want while you are able to make your own decisions.
- **THINK** about what you would want for you.
- **TALK** with your family and friends about your health care and end-of-life care.
- **ACT** – complete your Adv.Dir. Forms and share with your family, physician(s), DPOA-HC and attorney.

MEDICARE REQUIREMENTS FOR ADVANCE CARE PLANNING

Resource: Medicare Learning Network.

February 2023

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

- **“Advance care planning (ACP) is a voluntary, face to face service between an MD or other qualified healthcare professional(QHP) and a patient family member, caregiver or surrogate to discuss the patient’s health care wishes if they become unable to make their own medical decisions.”**

MEDICARE FACT SHEET WWW.MEDICARE.GOV

REQUIREMENTS FOR DOCUMENTATION ABOUT ACP

- **You must document your ACP discussion with a patient, family member, caregiver, or surrogate.**
- **In your documentation, include:**
  1. **The voluntary nature of the visit**
  2. **The explanation of advance directives**
  3. **WHO was present**
  4. **The time spent discussing ACP during the face-to-face encounter**
  5. **ANY change in health status or health care wishes if the patient becomes unable to make their own decisions.**

Resource: Medicare Learning Network

- **Diagnosis**
  - Report the condition you discuss with the patient using an ICD-10-CM code. This code shows an administrative exam or an exam diagnosis when the ACP services are part of the AWV or IPPE. You don't need to report a specific diagnosis to bill ACP.

- REQUIREMENTS FOR DOCUMENTATION ABOUT ACP

Resource: Medicare Learning Network

REQUIREMENTS FOR DOCUMENTATION ABOUT ACP

- **ACP Services are Time Based**
  - **You must follow CPT rules about minimum time requirements to report and bill ACP**
  - **You shouldn't discuss any other active management of a patient's issues for the time reported when you bill ACP codes.**
- **When you perform another service concurrently as a time-based service, do not include the time spent on the concurrent service with the time-based service.**
- **Do not bill any ACP discussion of 15 mins. or less as ACP.**

Resource: Medicare Learning Network

THREE TYPES OF ADVANCE DIRECTIVES

Durable Power of Attorney for Health Care (DPOA-HC)

Living Will

Do Not Resuscitate (DNR)

DO YOU HAVE ADVANCE DIRECTIVES FOR YOURSELF?

DURABLE POWER OF ATTORNEY – FOR HEALTH CARE (DPOA-HC)

- **The DPOA-HC is a document to have you name a healthcare agent to make healthcare decisions for you only when you cannot make decisions for yourself.**
- **Your HC agent may talk with your caregivers and help decide on a plan for your care.**
- **TALK with your HC agent – share medical contacts, hospitalization, quality of life values, experimental treatments or life-sustaining treatments you would or would not want.**
- **Your DPOA-HC agent MUST follow your wishes and care-givers must the RESPECT the choices your agent communicates for you.**

AREAS THAT ARE CONFUSING ABOUT DPOA-HC (K.S.A. 58-625 THROUGH 632)

- **May I take my DPOA-HC form with me on a trip? YES. Forms are honored in all 50 states**
- **Where should I get the forms notarized? Grocery store, physician's office, personal bank, hospital, or WMREF office by appointment.**
- **Who can witness my DPOA-HC form? Two persons who recognize that you are the person you say you are. They are recognizing you and your signature.**
- **Does the DPOA-HC form replace the HIPAA (Health Insurance Portability and Accountability Act-1996) form? NO.**
- **go to www.wichitamedicalresearch.org/frequentlyaskedquestions**

LIVING WILL DECLARATION

- **Also called "Kansas Natural Death Act"**
- **Signed by patient; notarized or witnessed**
- **"…my dying shall not be artificially prolonged under the circumstances set forth…"**
- **"If…I should have an incurable injury, disease, or illness certified to be terminal condition by two physicians who have personally examined me…"**
- **"…physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or …medical procedure deemed necessary to provide me with comfort care."**

WHAT DOES CPR MEAN?

- "CARDIOPULMONARY RESUSCITATION (CPR) is a life saving technique that is useful in many emergencies, such as a heart attack or near drowning, in which a person's breathing or heartbeat has stopped.

- The American Heart Association recommends starting CPR with hard and fast chest compressions. This hands-only CPR recommendation applies to both untrained bystanders and first responders."
  - mayoclinic.org

DO NOT RESUSCITATE

- DNR form can be done before a health crisis IF you wish not to be resuscitated if your heart stops.
- NOT for everyone.
- STOPS cardio-pulmonary resuscitation (not other treatments) .
- If the patient no longer has capacity, no one else can sign the DNR Directive form.
- Physician can discuss with DPOA-HC or decision makers and sign DNR orders in the hospital or care facility; write a DNR on prescription pad or complete a TPOPP/POLST form for home use.

AREAS THAT ARE CONFUSING ABOUT ADVANCE DIRECTIVES

DO NOT RESUSCITATE

- Is an Advance Directive done by the patient only.
- Only stops CPR.
- Does NOT stop tracheostomy, PEG tube, other treatments.
- **Kansas Statute: K.S.A. 65-4941. ET.SEQ**

LIVING WILL

- Is a signed and notarized or witnessed form that allows a person to state in advance that his/her dying should not be artificially prolonged in cases of terminal illness.
- Does not apply to a person in a coma or PVS unless the person is also diagnosed as terminally ill.
- **Kansas Statue: K.S.A. 65-28, 101 ET. SEQ.**

HOW TO IMPLEMENT ADVANCE DIRECTIVES INTO THE ORGANIZATION/CLINIC WORKFLOW

1

Assign & train admission nurse/personnel in clinic/hospital setting to ask if patient has advance directives

2

If person does not have AD, hand out brochure, **MAKE THE DECISION YOURS**(www.wichitamedicalresearch.org brochure)

3

Ask patient/resident to read brochure, ask questions next visit, or call WMREF (316-686-7172)

- Ask for forms
- Assess patient's knowledge, understanding, capacity of situation
- Confirm DPOA-HC
- Ask questions about patient wishes
- Concerns of patient
- Assess agent's understanding
- Document conversation

WHAT RESPONSIBILITY DOES THE HEALTHCARE PROFESSIONAL HAVE WHEN CARING FOR A PERSON WITH AN ADVANCE DIRECTIVE?

HOW DO ADVANCE DIRECTIVES WORK INTO PALLIATIVE CARE

- **An Adv. Dir. lets your physician(s), all caregivers, family and friends know your decision maker if you cannot make decisions.**

- **IF you have the conversation with your DPOA-HC, hopefully your agent will know your wishes for healthcare services: your desire for diagnostic tests, surgical procedures, CPR, long-term care, hospital(s), types of special treatments (ex:CPR or DNR) you want or don't want in your healthcare journey and at end-of-life.**

Adv. Dir. help to do PERSON centered care

Drawing upon an individual's needs, values and expectations helps guide decision-making and caregiving.

Who is making sure an Adv. Dir. Is followed?

- **The patient/resident is personally responsible for completing the documents. No one can do the forms for another person.**

- **The patient/resident should give a copy of their Adv. Dir. to all physicians, the agent and other family members/friends who patient feels needs a copy.**

- **The agent/DPOA-HC/Surrogate's job is to make sure the person's Adv. Dir. is given to the hospital staff caring for the patient.**

Who is making sure and Adv. Dir. Is followed?

- **The agent's job is outlined in the statute of the DPOA-HC. (See DPOA-HC handout)**

- **The job lies with all of us as caregivers. You may be the respiratory therapist, the nurse in charge or doing direct patient care, trauma surgeon, family physician, oncologist, etc.**

How do we do this serious illness conversation?

How do we start the conversation?

- See SERIOUS ILLNESS CONVERSATION GUIDE. (Ariadne Labs).
- Practice your conversation questions.
- Get comfortable with asking serious illness conversations.

Conversations are too little, too late and not great!

Multiple studies show patients with serious medical illnesses do not discuss EOL preferences, or first discuss them only in the last days to month of life.

Wright 2008, Dow 2010, Halpern 2011

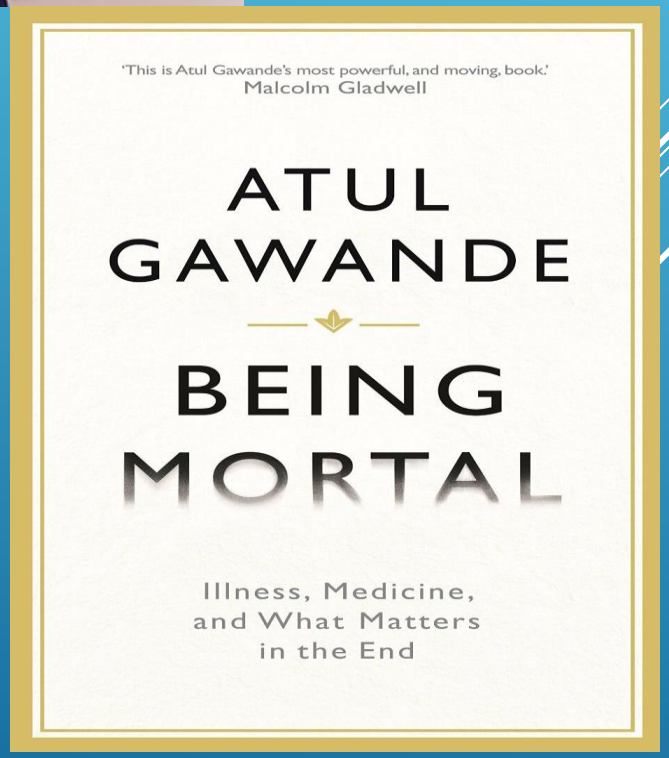
Conversations are Key

Earlier conversations about patient goals and priorities for living with serious illness are associated with:

- **Enhanced goals of care** Mack JCO 2010
- **Improved quality of life**
- **Reduced suffering**
- **Better patient and family coping**
- **Higher patient satisfaction** **Detering BMJ 2010**
- **Less non-beneficial care and costs** **Wright 2008, Zhang 2009**

SERIOUS ILLNESS CONVERSATION GUIDE

- Was developed by a physician, Atul Gawande, at Ariadne Labs.
- Developed to assist MD's and other health care professionals when having difficult conversations with patients and/or family members.
- The words and phrases in the guide have been tested and found to help patients understand the conversation better.



POINTS FOR CONSIDERATION IN LTC RE: ADV. DIR.

- **Policies and Procedures**
- **Maintain consistency through staff changes.**

Put Serious Illness Care Planning into action

- Develop institutional algorithms to identify seriously ill patients, where the surprise question, "Would you be surprised if this patient dies in the next year?" and if the answer is "no," it is time!
- Develop workflows and training for providers to have more, better, earlier serious illness care planning conversations, using the Serious Illness Conversation Guide.

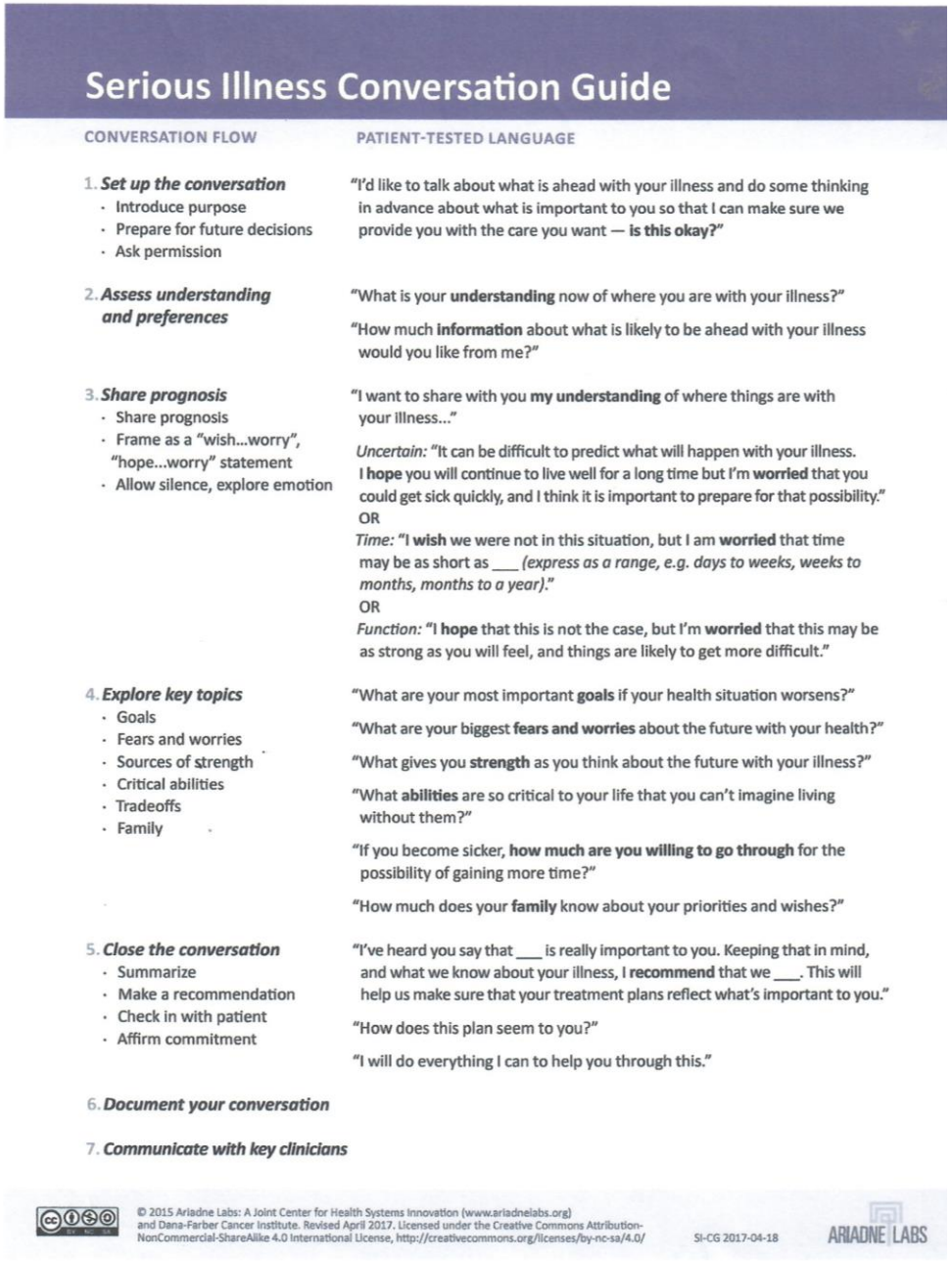
Potential Outcomes of Serious Illness Conversations

Conversation must be documented in medical record

- Needs to be in a place where it is EASILY accessed by other providers. TPOPP/POLST form can be used.
- Person's *current goals and wishes* are documented and can change.
- Can be billed by provider for using ACP codes activated by CMS January 1, 2016

ALL levels of care NEED the communication about patient.

Practice!!



Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. ***Set up the conversation*** · Introduce purpose · Prepare for future decisions · Ask permission	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"
2. ***Assess understanding and preferences***	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. ***Share prognosis*** · Share prognosis · Frame as a "wish...worry", "hope...worry" statement · Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness..." *Uncertain:* "It can be difficult to predict what will happen with your illness. **I hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." OR *Time:* "**I wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year).*" OR *Function:* "**I hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. ***Explore key topics*** · Goals · Fears and worries · Sources of strength · Critical abilities · Tradeoffs · Family	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. ***Close the conversation*** · Summarize · Make a recommendation · Check in with patient · Affirm commitment	"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. ***Document your conversation***	
7. ***Communicate with key clinicians***	

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ARIADNE LABS

A guide to start the conversation

Go to: www.ariadnelabs.org OR www.talkaboutwhatmatters.org

Serious Illness Conversation Guide

revised April 2017 version

RESOURCES

- JUST ASK – **A Conversation Guide for Goals of Care Discussion.** www.advancecareplanning.ca(Canadian website)

- **SERIOUS ILLNESS CONVERSATION GUIDE**: GOOGLE: Serious Illness Conversation Guide with Ariadne Labs.

  This is a Joint Center for Health Systems Innovation (www.ariadnelabs.org) and Dana-Farber Cancer Institute. Revised April 2017.

TRUSTED SOURCES FOR ADVANCE DIRECTIVES -----AVAILABLE FREE

- **www.wichitamedicalresearch.org/advancedirectives** Click on which directive you want, download and print. Website has a list of *Frequently Asked Questions* about Advance Directives
- Hospitals, physician offices, clinics, will ask for these documents. Take copies with you. They may ALSO make copies of your forms to place in YOUR file.
- **www.nhpco.org** National Hospice and Palliative Care Organization has advance directives for ANY state in the USA.
- **www.practicalbioethics.org** has advance directives for Missouri, and has *Caring Conversations* workbook.

What QUESTIONS do you have?