Advance Directives: Planning in Advance

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Objectives

- Define Advance Care Planning & Advance Directives
- Historical Timeline
- Evidence Behind Advance Directives
- Practical Applications in Clinical Practice

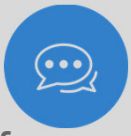
Advance Care Planning (ACP)

- ACP focus is communication
- Can be facilitated with some various types of guides or aids for planning
- Billable service
- Documentation is either AD or charting
- Can be facilitated by clinician or independent by individual
- NOT require lawyer but often part of estate planning

Advance Directives (AD)

- Living Will
- Health Care Power of Attorney
- Do Not Resuscitate (DNR) order
- …orders for life-sustaining treatment (POLST or MOLST)

ACP vs AD



ACP or Advance Care Planning is focused on the process, mainly about COMMUNCIATION.

AD or Advance Directives is focused on the products, or the legal DOCUMEMNTS.

Living Will

- LEGAL document
- express one's wishes, preferences, and LIMITS
- of FUTURE hypothetical situation
- preserving AUTONOMY of individual's choice
- guides clinicians & families in an IF/THEN scenario

Health Care Power of Attorney

- LEGAL document
- identifying individual's DESIGNATE
- to MAKE DECISIONS on the individual's behalf
- if/when individual is INCAPCITATED
- guides clinicians & families in an IF/THEN scenario

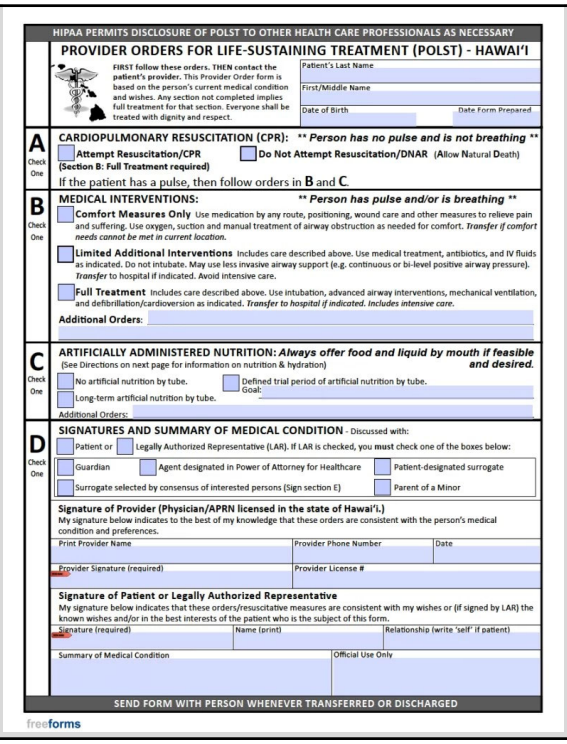
Do NOT resuscitate (DNR)

- LEGAL document
- identifying LIMIT of CPR (cardiopulmonary resuscitation)
- guides clinicians & families in an IF/THEN scenario, specifically with cardiac or respiratory arrest

POLST/MOLST

- LEGAL document
- Portable Medical Orders: (life sustaining treatments)
- Not legal in all states including Ohio
- more specific on LIMITS beyond CPR

POLST



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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAI'I

FIRST follow these orders. THEN contact the patient's provider. This Provider Order form is based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name | First/Middle Name | Date of Birth | Date Form Prepared

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** ** *Person has no pulse and is not breathing* **

☐ **Attempt Resuscitation/CPR** (Section B: Full Treatment required) ☐ **Do Not Attempt Resuscitation/DNAR** (Allow Natural Death)

If the patient has a pulse, then follow orders in **B** and **C**.

B Check One — **MEDICAL INTERVENTIONS:** ** *Person has pulse and/or is breathing* **

☐ **Comfort Measures Only** 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. *Transfer if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). *Transfer* to hospital if indicated. Avoid intensive care.

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

Additional Orders:

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** ***Always offer food and liquid by mouth if feasible and desired.***

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. Goal:

☐ Long-term artificial nutrition by tube.

Additional Orders:

D Check One — **SIGNATURES AND SUMMARY OF MEDICAL CONDITION** - Discussed with:

☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate

☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Provider Name | Provider Phone Number | Date

Provider Signature (required) | Provider License #

Signature of Patient or Legally Authorized Representative

My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

Signature (required) | Name (print) | Relationship (write 'self' if patient)

Summary of Medical Condition | Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

freeforms

Historical Timeline: Advance Directives

- Lack clear “starting line”
- Response to social and technological changes

- Living Will dates back to 1967, Luis Kutner
- Power of Attorney dates back to “common law” colony
- Patient Self-Determination Act (PSDA) Dec 1991

Federal versus State Authority

- Minimal, notably the Patient Self-Determination Act (PSDA) Dec 1991

- Otherwise, it defers to state law

- ONE exception is military personnel, preempts state law.

Land Mark Cases

- Karen Ann Quinlan
- Nancy Cruzan
- Terri Schiavo

Shortcoming of AD

*The committee, **while recognizing the value of advance directives**, questions the urgency of intensive efforts to universalize their use. In this area of decision making at the end of life, the law's favorite product—the legally binding document—may sometimes **stand in the way of, rather than ease**, the process, especially if these documents are naively viewed as ultimate solutions to the difficulties of decision making. Rather, the documents known as advance directives should be seen as a **set of tools** useful in the ongoing process of advance care planning.*

- *(IOM 1997, 203)*

SUPPORT Trial

- phase I observation documented shortcomings
  - in communication,
  - frequency of aggressive treatment,
  - and the characteristics of hospital death
- phase II
  - patients experienced no improvement in patient-physician communication
  - or in the five targeted outcomes

ACP is a billable service

- Advance care planning (ACP)
  - voluntary
  - face-to-face discussion
  - between a clinician
  - patient, their family member, caregiver, or surrogate
  - to discuss the patient's health care wishes if they become unable to make their own medical decisions

ACP documentation

In your documentation, include:

- visit was voluntary
- explanation of advance directives
- who was present
- time spent discussing ACP during the face-to-face encounter
- any change in the patient's health status
- The patient's health care wishes if they become unable to make their own decisions

ACP is a billable service

Table 1. Time Thresholds and Ranges for Medicare Reimbursement for Advance Care Planning Services

Time in ACP (minutes)	ACP CPT code(s)
0–15	Not separately billable
16–45	99497
46–75	99497 and 99498
76–105	99497 and 99498 x 2
106–135	99497 and 99498 x 3

ACP, advance care planning; CPT, current procedural terminology.

Source: Jones, Christopher A et al. "Top 10 Tips for Using Advance Care Planning Codes in Palliative Medicine and Beyond." *Journal of palliative medicine* vol. 19,12 (2016): 1249-1253. doi:10.1089/jpm.2016.0202

Evidence

- Legislations, institutional policies, and cultural factors influence ACP development.
- Positive perceptions toward ACP do not necessarily translate into more end-of-life conversations.
- Many factors related to patients' and providers' attitudes, and perceptions toward life and mortality influence ACP implementation, decision making, and completion.

Evidence

- Limited, low-quality evidence points to several ACP benefits, such as improved end-of-life communication, documentation of care preferences, dying in preferred place, and health care savings.
- Recurring features that make ACP programs effective include **repeated and interactive discussion sessions**, decision aids, and interventions targeting multiple stakeholders.

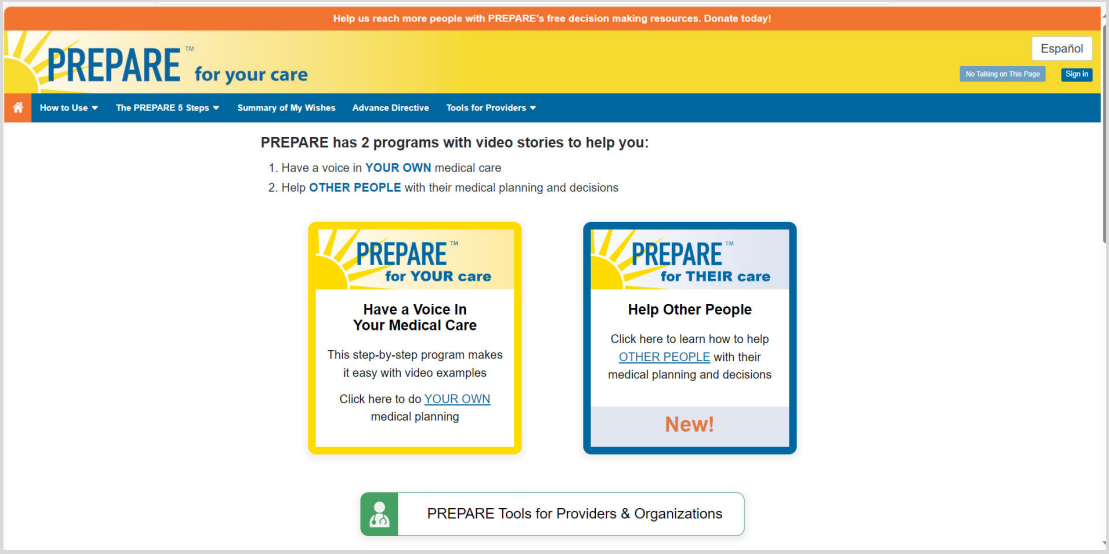
Applications in Clinical Practice

- ACP starts with communication.
- Advance Directives can be an unfamiliar and uncomfortable conversation for clinicians and patients/families.
- Numerous Tools/Guides/Protocols

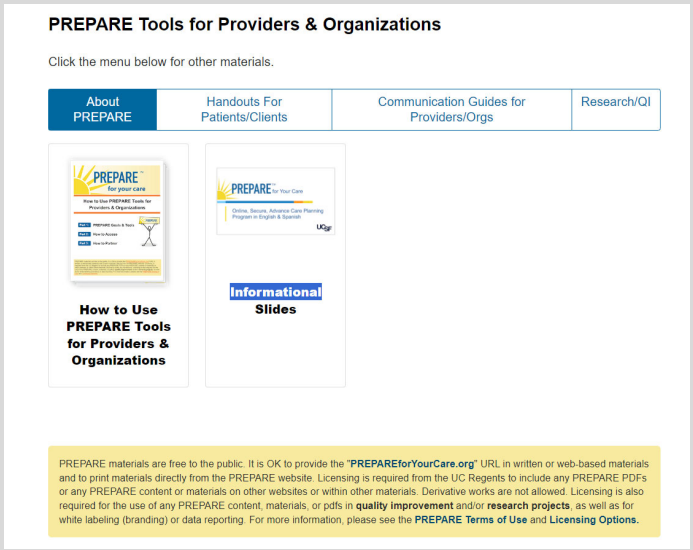
Applications in Clinical Practice

- Fee-based service:
  - Attorney
  - Commercial Products
- FREE-based service:
  - Patient
    - https://prepareforyourcare.org/en/welcome
    - https://theconversationproject.org/
  - Clinician
    - https://www.ariadnelabs.org/wp-content/uploads/2023/05/Serious-Illness-Conversation-Guide.2

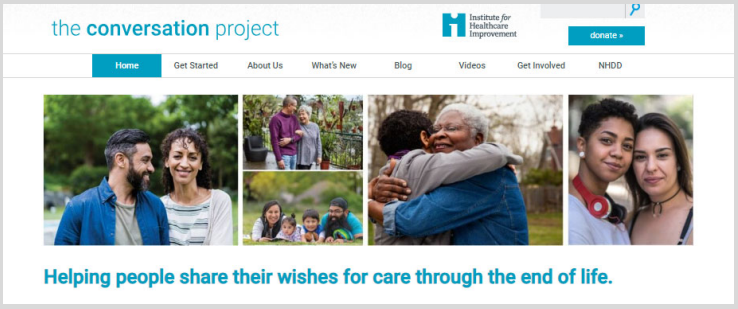
Prepare For Your Care

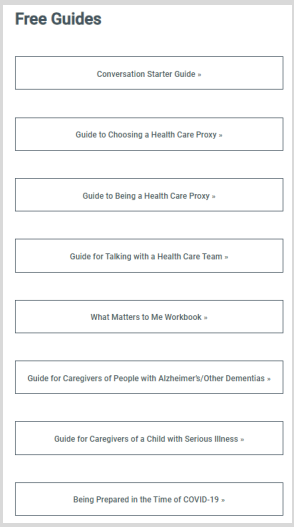


Prepare For Your Care

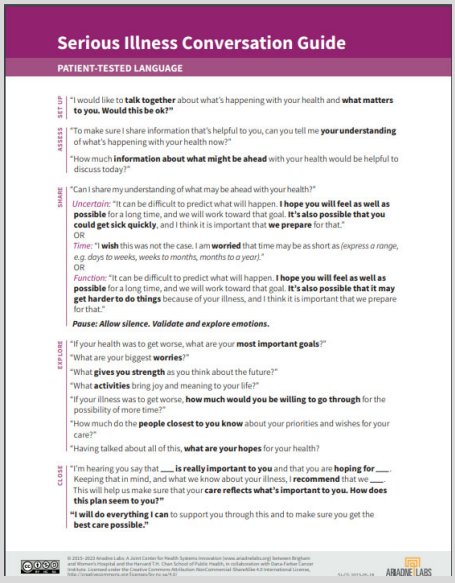


The Conversation Project





Serious Illness Conversation Guide



Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

SET UP

"I would like to **talk together** about what's happening with your health and **what matters to you. Would this be ok?"**

ASSESS

"To make sure I share information that's helpful to you, can you tell me **your understanding** of what's happening with your health now?"

"How much **information about what might be ahead** with your health would be helpful to discuss today?"

SHARE

"Can I share my understanding of what may be ahead with your health?"

Uncertain: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time, and we will work toward that goal. **It's also possible that you could get sick quickly**, and I think it is important that **we prepare** for that."

OR

Time: "I **wish** this was not the case. I am **worried** that time may be as short as *(express a range, e.g. days to weeks, weeks to months, months to a year)*."

OR

Function: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time, and we will work toward that goal. **It's also possible that it may get harder to do things** because of your illness, and I think it is important that we prepare for that."

Pause: Allow silence. Validate and explore emotions.

EXPLORE

"If your health was to get worse, what are your **most important goals**?"

"What are your biggest **worries**?"

"What **gives you strength** as you think about the future?"

"What **activities** bring joy and meaning to your life?"

"If your illness was to get worse, **how much would you be willing to go through** for the possibility of more time?"

"How much do the **people closest to you know** about your priorities and wishes for your care?"

"Having talked about all of this, **what are your hopes** for your health?

CLOSE

"I'm hearing you say that **____ is really important to you** and that you are **hoping for ____**. Keeping that in mind, and what we know about your illness, I **recommend** that we ____. This will help us make sure that your **care reflects what's important to you. How does this plan seem to you?"**

"I will do everything I can to support you through this and to make sure you get the **best care possible."**

ARIADNE LABS

History Advance Directives

Advance Directives/Care Planning: Clear, Simple, and Wrong
R. Sean Morrison
Journal of Palliative Medicine 2020 23:7, **878-879**

Advance care planning and advance directives: an overview of the main critical issues
Sedini C, Biotto M, Crespi Bel'skij LM, Moroni Grandini RE, Cesari M.
Aging Clinical Experimental Research 2022 Feb:34(2): 325-330.

The evoluation of health care advance planning law and policy
Sabatino CP
Milbank Quarterly. 2010 Jun; 88(2):211-39.

History Advance Directives

What is the evidence for efficacy of advance care planning in improving patient outcomes? A systematic review of randomised controlled trials.
Malhotra C, Shafiq M, Batcagan-Abueg APM.
BMJ Open 2022 Jul 19;12(7):e060201.

Looking Back at Withdrawal of Life-Support Law and Policy to See What Lies Ahead for Medical Aid-in-Dying.
Capron AM.
The Yale Journal of Biology and Medicine. 2019 Dec 20;92(4):781-791

SUPPORT Study
Journal of American Medical Association. 1995 Nov 22-29;274(20):1591-8.
Erratum in: JAMA 1996 Apr 24;275(16):1232.

Resources

- Veterans Affairs Advance Directives
- PREPARE (prepareforyourcare.org)
- The Conversation Project - Have You Had The Conversation?
- Serious Illness Conversation Guide
- CMS - Advance Care Planning Annual Wellness Visit