Advance Care Planning in New Hampshire

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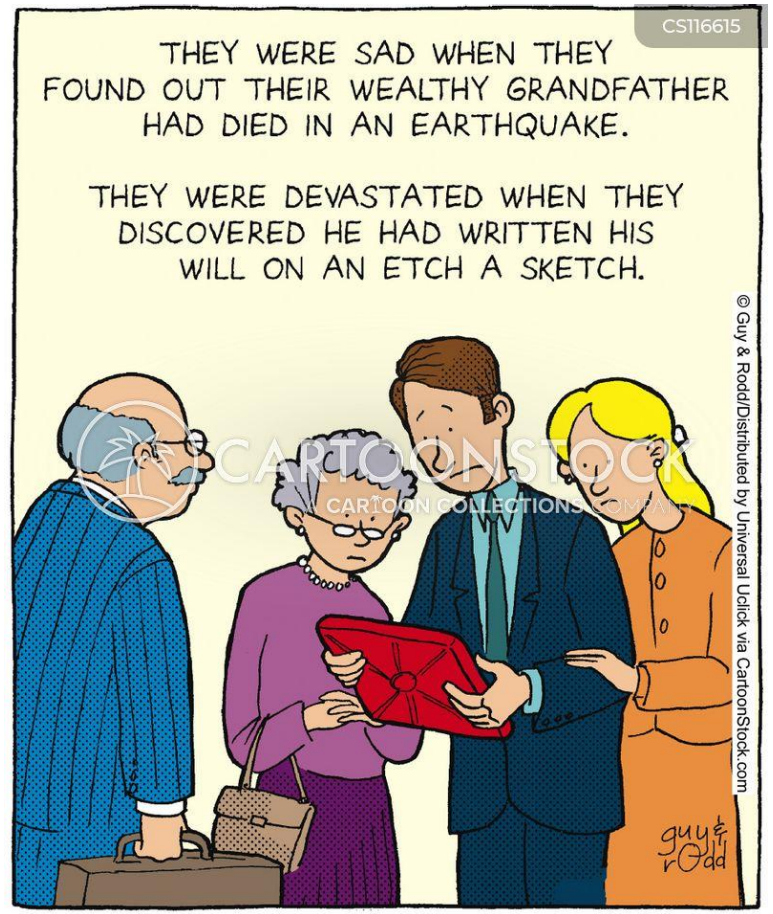
Information to Review

- Documents in NH- Portable DNR, Advance Directive, POLST
- Options when no documentation in place- surrogate decision makers, guardianship
- Starting conversations with patients
- Documentation in Medical Records
- Billing for services
- Cultural, spiritual considerations
- Complex Case Reviews

Excuse me. Excuse me. I need a new torso. This one has a do not resuscitate order.



Advance Care Planning

- Builds trust
- Reduces uncertainty
- Improves patient autonomy
- Helps avoid confusion and conflict
- Permits peace of mind
- Reduces unnecessary hospital admissions
- 1/3 population has completed

https://vimeo.com/242652058

Vital Talk- Addressing Advance Directives

New Hampshire
"DNR"

SEND ORIGINAL PINK FORM WITH PATIENT

WHEN TRANSFERRED OR DISCHARGED

FOUNDATION FOR HEALTHY COMMUNITIES

PORTABLE DO NOT ATTEMPT RESUSCITATION (P-DNR) ORDER

This is a Physician/Advanced Registered Nurse Practitioner Order Sheet. It is based on patient wishes and medical indications regarding *Do Not Attempt Resuscitation (DNR)* orders in the event of cardiac or respiratory arrest, as discussed with the patient.

Last Name of Patient

First Name/Middle Initial of Patient

Patient's Date of Birth | **Last 4 Digits of SSN**

A. **Applies only when patient is not breathing or has no pulse. Check box and complete mandatory signature lines in sections A and B.**

☐ **Do Not Attempt Resuscitation (DNR)**

(DNR means: No chest compressions, No intubation, No assisted ventilation, No defibrillation, No pharmacologic resuscitation.)

Physician/ARNP Name (Print) | Physician/ARNP Signature **(Mandatory)** | Date and Time

Other instructions or special circumstances *(if applicable)*

HOW TO CHANGE THIS FORM

This form (P-DNR) **should be reviewed** if:

- the patient changes his or her decision or
- there is substantial change in patient's/resident's health status, or
- the patient is admitted to a new facility.

If this form is to be voided, write the word "VOID" in large letters, and then sign, date, and time the form. If applicable, please advise the patient to destroy his or her P-DNR wallet card or remove his or her DNR bracelet or necklace. After voiding the form, a new form may be completed. **If no new form is completed, full treatment and resuscitation may be provided.**

B. **Advance Directives and Other Patient Wishes:**

Does the patient have a/an:

Durable Power of Attorney for Healthcare?	☐ NO	☐ YES - Document location:_____
Living Will?	☐ NO	☐ YES - Document location:_____
Organ or Tissue Donation?	☐ NO	☐ YES - Document location:_____
Court-appointed Guardian Over the Person?	☐ NO	☐ YES - Document location:_____

Patient, Parent of Minor, Durable Power of Attorney for Healthcare or Guardian Information:

Name (Print) | Signature **(Mandatory)** | Date and Time

Address of Parent of Minor, Durable Power of Attorney for Healthcare (DPOAH) or Guardian | Phone Number of Parent, DPOAH or Guardian

Name of Person Preparing Form (Print) *(if applicable)* | **Signature of Person Preparing Form** | **Date and Time**

SEND ORIGINAL PINK FORM WITH PATIENT WHEN TRANSFERRED OR DISCHARGED

FHC 1/29/07

DO NOT ALTER THIS FORM !

Made Fillable by eForms

Was the P-DNR Card below completed and retained by the patient? ☐ NO ☐ YES

THIS IS YOUR PORTABLE DNR CARD. REMOVE THE CARD BELOW AND KEEP IT ON YOUR PERSON AT ALL TIMES EVEN IF YOU DECIDE TO WEAR A NH-DNR BRACELET.

Fold card down center line

Portable-DNR

NEW HAMPSHIRE **DO NOT ATTEMPT RESUSCITATION** ORDER

As this person's attending physician or ARNP and as a licensed physician or ARNP, I order that this person SHALL NOT BE RESUSCITATED in the event of cardiac or respiratory arrest.

Patient Name (Print) | Patient Signature / Date

Physician/ARNP Name (Print) | Physician/ARNP Signature / Date

If applicable: Health Care Agent Name (Print) | Health Care Agent Signature / Date

Portable-DNR

Patient Address

Patient Phone Number

Physician/ARNP Address

Physician/ARNP Phone Number

Health Care Agent Address

Health Care Agent Phone Number

Portable Do Not Resuscitate DNR

- Pink Paper
- Medical Order
- Follows patient

- FPDR- family presence during resuscitation
  - 1-2 family members into care area- required trained facilitators screen the family, and provide constant supervision and emotional support
  - Some areas this allowed ER, trauma room, ICU, post procedure recovery and inpatient units

CPR Poor Outcomes

- Unwitnessed arrest
- Asystole
- Electrical – mechanical dissociation
- Greater than 15 min resuscitation
- Metastatic cancer
- Multiple chronic diseases
- Sepsis
- Seriously ill patients
- Frail Patients- high risk for rib fractures and possible liver and spleen punctures
- Creatinine >1.5
- Dementia
- Dependent Status

CPR Survival Rates

- Survival Rate on TV 66%

In Hospital (2000-2002 207 hospitals, 14,720 patients)

- Survival 20 minutes after CPR 44%, however only 17% survived to discharge
- Survival for discharge ventricular fibrillation and pulseless ventricular tachycardia was 34-35%
- Survival Asystole 10%

(Peberdy MA, Kayne W, Ornator JP et al. Cardiopulmonary resuscitation od adults in the hospital: A report of 14,720 cardiac arrests from the National Registry of Cariopulmonary Resuscitation. Resuscitation. 2003:58 297-308.)

Cancer patients survival less than 2% - meta analysis 1966- 2005 since 1990 now 6.7% survive

Dialysis patients- 14% survive to discharge- 3% survived past 6 months

(Reisfield GM, et all. Survival in cancer patients undergoing in- hospital cardiopulmonary resuscitation: a meta- analysis. Resuscitation. 2006; 71:152-160)

CPR survival rates

- Adults older, frail living in nursing facility- CPR success rate 2%

(Shah, Fairbanks, Lerner (207) Cardiac arrest in skilled nursing facilities continuing room for improvement? J Am Med dir Assoc. 8(3 supple 2): e-27-31)

CPR what's safe to say

- Roughly 15% or 1 in 6 patients who undergo CPR in the hospital may survive
- Less than 5% for elderly and those with serious illness

Perception of prognosis

- 1994 Murphy asked 371 adult over 65 wanting CPR before learning probability of survival
- 41% wanted CPR
- After discussion only 22% wanted it
- Anyone with life expectancy 1 year or less- 5% wanted

(Murphy, DJ et al. The influence of the probability of survival on patients' preferences regarding cardiopulmonary N Engl J Med. 1994 Feb 24; 330 (8): 545-9.)

POLST

- Medical order form indicating life-sustaining treatment choices for seriously ill patients.
- Life expectancy one year or less
- Portable Medical Orders
- Initiated in 1991 in Oregon
- State Specific
- Bright yellow form
- Physician or Nurse Practitioner can sign

POLST: When Advance Directives Are Not Enough - YouTube

POLST treatment- can reduce ICU admissions

- Study 2 Seattle teaching hospitals from 2010-2017
- 38% of patients with treatment limiting POLST received potentially unwanted intensive care near the end of life
- Upon admission 22% of patients had a POLST order for comfort measures only, 42% for limited interventions and 36% for full treatment
- 39% patients died during the study hospitalization
- ICU admission occurred 31% of patients with comfort- only orders
- 46% with limited intervention order and only 1% of ICU admission was for sole purpose of symptom management.
- One of more life- sustaining treatments were received by 14% of comfort measures only patient, and 20% limited- intervention patients

Advance Directives

- Foundations for Healthy Communities Booklet
- Prepareforyourcare.org
- Caring Conversations – Center for Practical Bioethics
- Can be completed by patient alone (notarized or 2 witnesses), done with medical personnel, attorneys with estate planning

Durable Power of Attorney

- Choosing someone to make healthcare decisions for you when you cannot make or communicate decisions for yourself
- Takes effect when unable to make decisions- even temporary unconscious, or during surgery
- Power to make any health care decisions for patient
- Under New Hampshire Law if terms in advance directive conflict- DPOAH will overrule the living will

Healthcare agent / DPOA CAN'T

- Commitment to a state institution; psychosurgery; an experimental treatment of any kind; or sterilization
- Termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy, unless the treatment will be physically harmful to patient or prolonged severe pain which cannot be alleviated by medication

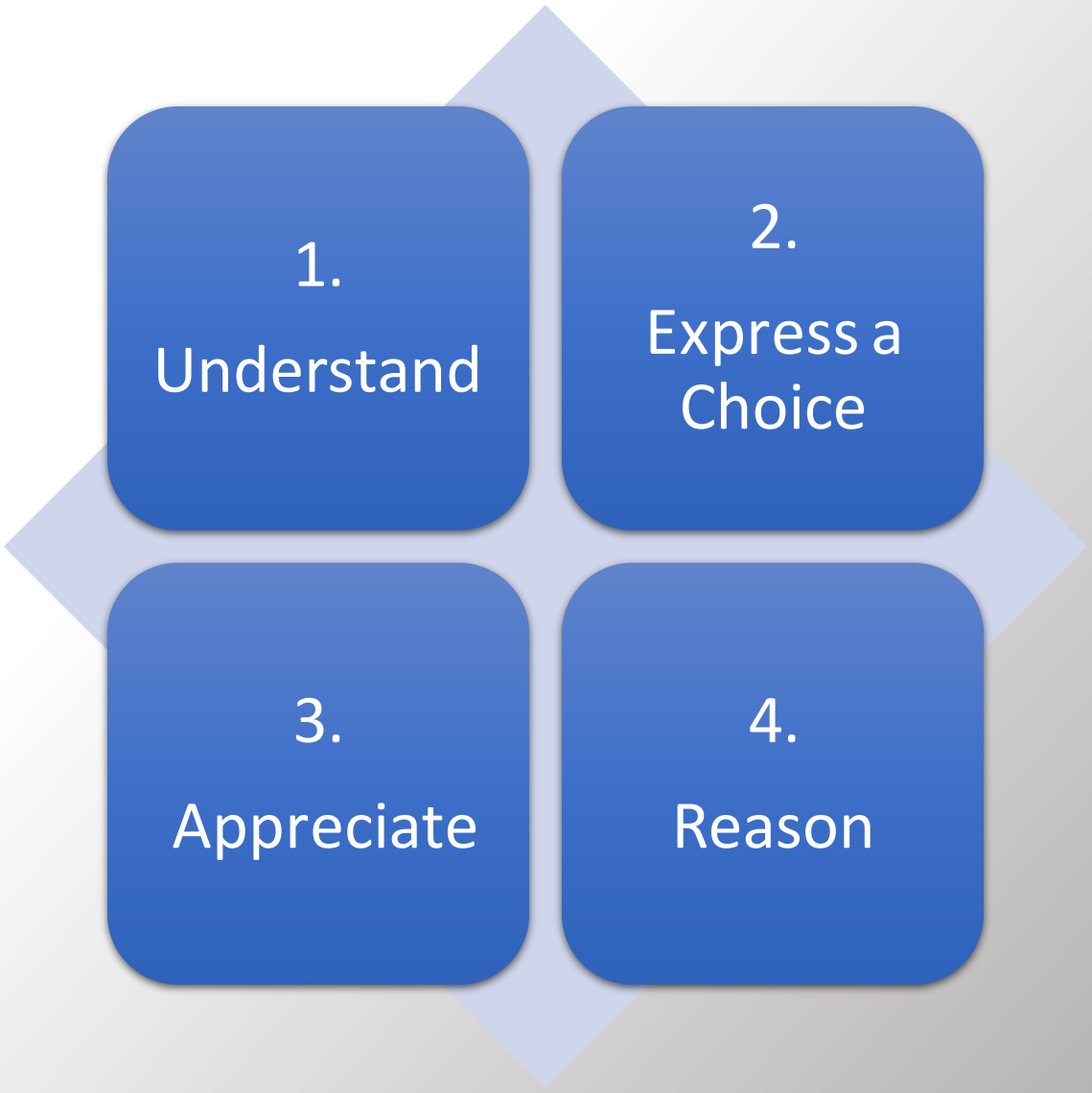
Living Will / Health Care Treatment Directive

- Takes effect only when condition is no hope for recovery

Lacking Capacity

- Patient has choice to choose for moral or religious reason someone other than a physician or nurse practitioner to certify for lack of capacity. Can not be healthcare agent or alternate health care agent or any person ineligible to be your health care agent

Determining Medical Decision-Making Capacity



Determining Medical Decision Capacity

- Understand
  - Understand the details of their medical choice and treatment and plan options and re-state the important features to demonstrate understanding
- Express a Choice
  - Express and sustain a choice.
- Appreciate
  - Appreciate and acknowledge the information
- Reason
  - Reason and provide rational for their decisions. Reasoning is influences by values and beliefs and some rationale supports capacity

Determining Medical Decision- Making Capacity

- “We have talked about the medical situation you are facing and possible treatments for these issues or problems. Just to make sure we are working together on same page- can you describe the medical problems you are dealing with now?”
- “Can you also describe possible treatments we have discussed?”

- PCP responsible typically in determining, can consult with mental health if concern

- ACE- Aid to Capacity Evaluation (see handout)

Optional Documentation

- 5 wishes
- Caring Conversations – Center for Practical Bioethics
- Dementia-directive.org
- Theconversationproject.org- advance directives and also specific for Alzheimer's
- Making Medical Decisions for Someone Else- NH Handbook
  - New Hampshire Judicial Branch - Circuit Court Probate Division (state.nh.us)

Guardianship

- Appointed by Probate Court in county where person resides
- Petition includes facts about essential need for guardian to avoid immediate injury and absence of any practical alternatives
- Anyone interested in welfare of person can petition- including facility where patient located
- Provide specific and recent examples within 6 months
- Form online- NH probate court website
- Need to appointment public gaurdian if not another option

Medical Surrogacy

- Temporarily recognized the authority of a relative or friend to make healthcare decisions in absence of advance directive until patient death, guardian appointed or 180 days pass (which ever first)
- Individual names as surrogate by provider – must be willing and able
- If surrogate found with higher priority during care, must be replaced if wanted
- Similar to agent under advance directive

Medical Surrogacy

- Law sets priority
  - Patient spouse, civil union or common law spouse
  - Adult son or daughter
  - Either parent of patient
  - Any adult sibling
  - Any adult grandchild
  - Any grandparent
  - Any adult aunt, uncle, niece or nephew
  - A close friend
  - The agent with financial power of attorney or conservator appointment in accordance with RSA 464-A
  - The guardian of patient’s estate

Starting and Having Conversations

Ask- Tell- Ask

- Asking open ended questions
- Determine patients understanding before sharing information
- Collaborative

- Why?
  - Find out how patient feeling, if ready to hear information, want to know about their health, discover barriers or challenges

What to Say… REMAP

- Reframe
- Emotion
- Map
- Align
- Propose a Plan

Table 1. Examples of Clinician Statements to Guide Conversations Regarding Goals of Care

REMAP	Physician Statement
Reframe	"You've worked very hard with all the treatments over the years, and I hear that now you're feeling more tired and it's harder for you to do the things you enjoy. I'm seeing that you're in a different place now. Further treatments may be too hard on you."
Emotion	"What worries you most about this?" "It's understandable that you would feel sad when thinking about these things." "This is hard to talk about." "Is it OK to talk about what this all means for the future?"
Map	"Tell me about some of the things you enjoy doing." "What's most important to you given that time is limited?"
Align	"From what I'm hearing from you, the most important thing for you is to have time at home, sitting on the porch with your family. You feel like at this point you've spent too much time in the hospital, and you wouldn't want to come back if it could only extend your life a few days or weeks."
Propose a Plan	"Given what you've told me, I'd propose that we do everything to help you spend time at home with your family. I don't think more cancer treatment is likely to help with that. I think getting hospice involved would help you do what you want to do with the time you have. What do you think?"

Childers,J., Back, A., Tulsky, J., Arnold, R. REMAP:A Framework for Goals of Care Conversations. Journal of Oncology Practice. 2017; 13, 10 :e844-850

What to Say… The 3 Ws

- The 3 Ws
- Wish , Worry, Wonder

- I wish we could cure/ fix your lungs, heart, etc
- I worry your body is getting weaker / you will require future hospitalizations.
- I wonder if you would like to discuss how you would like to be care for your goals.

What to Say… SPIKES

- Setting
- Perception
- Invitation
- Knowledge
- Empathy
- Summarize or Strategize

SPIKES

- Setting
  - Think about what you want to say in advance
  - Quiet and private place , allow time for patient to express emotions and questions
- Perception
  - Assess patients understanding of their medical condition using open ended questions
- Invitation
  - Ask permission to engage in conversations about sensitive topic
- Knowledge
  - Give patient information about their condition, treatment plan, prognosis, provide support. (small amounts and confirm regularly they understand)
- Empathy
  - Being empathetic can soften the impact, permits moving forward to discuss strategy
- Summarize or Strategize
  - Ask patient if they understand the plan, reflection can be helpful.
  - Close with a clear summary of situation, and ask if patient has more questions

Showing Empathy - NURSE

- Name the emotion you are seeing
- Understand- try to put yourself in their position/ their shoes
- Respect- recognize and empower
- Support- support the patient- your plan to stay and engage in care
- Explore- non-judgmental open questions to explore emotion

11 Tips for Patient Centered Goal-of-Care

- Prepare ahead of time for the conversation
- Establish rapport and ask permission to begin the conversation
- Use good communication skills to convey empathy and encourage engagement
- Employ shared decision making
- Incorporate high-quality, evidence-based patient decision aids, where appropriate
- Take the patient's health literacy into consideration
- Use plain language
- Confirm patient's concerns and values by restating them as understood
- Use the Ask-Tell-Ask technique when discussing a poor prognosis
- Allow for and manage emotions before moving forward with the conversation
- Revisit the discussion regularly, especially if the patient's health status changes

Negotiation of Differences

- Dr Timothy Quill – Caring for Patients at The End of Life
  - Listen and learn about each others position
  - Separate the person from the problem
  - Invent solutions of mutual gain
  - Call in third party
  - Take a “time-out”
  - Give in on nonessential areas
  - Explore the likely effects of choice
  - Know your bottom line

Documentation for Charting from CAPC

- Met with patient who was willing to discuss advance care planning.
- Or met with xxx to discuss advance care planning as patient unable to participate due to xxx

- Our advance care planning conversation included discussion about:
- - the value and importance of advance care planning
- - experiences with loved ones who have been seriously ill or who have died
- - exploration of person, cultural or spiritual beliefs that might influence medical decisions
- - exploration of goals of care in the event of a sudden injury of illness
- - identification and preparation of a health care agent
- - review and update, or completion of advance care directive document / portable DNR/ POLST
- - start and end time

Billing

- 99497: “Advance Care Planning including the explanation and discussion of advance directives such as standard forms (including the completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family members and/or surrogate”
  - At least 16 minutes
  - 1.5 RVU
- 99498 (add-on): Each additional 30 minute- can use multiple times
  - 1.4 RVU
  - Example 106-135 minutes 99497, 99498 x 3

Billing

- Can be performed any location by any qualifying provider
  - Qualified providers physicians, clinical nurse specialist, nurse practitioners, physician assistants
- Can be added with medicare wellness visits
- No limit on how many times bill in a certain time period– document changes/ reasons
- Forms do not have to be completed to bill
- Non qualifying may complete conversations and billing as “incident to”- check with billing specialists

Spiritual Assessment

- “Fear of death is universal. Death is fearful, frightening happening even if we think we have mastered it.” Elizabeth Kübler-Ross
- Some universal concerns spiritually or existential in regards to mortality.
- Three Dimensions of Spiritual Needs
  - Situation transcendence
  - Moral and biological Transcendence
  - Transcendence

FICA Spiritual Assessment Tool

- F: Faith and Belief
  - Do you consider yourself spiritual or religious?
  - Is spirituality something important to you
  - Do you have spiritual beliefs that help you cope with stress/difficult times?
  - What gives your life meaning ?
- I: Importance
  - What importance does you spirituality have in your life?
  - Has your spirituality influenced how you take care of yourself, your health?
  - Does your spirituality influence you in your healthcare decisions?
- C: Community
  - Are you part of a spiritual community?
  - Is this a support to you and how?
  - Is there a person or group of people you really love or who are important to you?
- A: Address Care Issues
  - How would you like me, your health care provider, to address these issues in your health care?

General Overview Religious Views Effecting End of Life Care

Religion	Core Principles	Potential Treatment Issues
Judaism	One God, Hebrew Gods chosen people, sanctity of life and body, debate about afterlife	Possible aggressive care and avoid interventions that scar the body
Christianity / Catholicism	Jesus Christ Savior, salvation through faith and good deeds, humans sinful and sanctity of life	Miracles and sanctity may prolong aggressive care Sacraments and rituals
Islam	Submission to the will of God, 5 pillars, sanctity of life	Same gender clinicians, sanctity may prolong aggressive care, keep body covered as much as possible
Hinduism	Samsara, Karma, Dukkja, Moksha	Face death with clear mind and focus on Braham and advance to higher state. Possible concerns with opioids, benzos and state of dementia and delirium. Family and friend support more while dying
Buddhism	Goal to end cycle of suffering. Pain, impermanence, egolessness. 4 Nobel Truths and eightfold Path	Concerns as above with clarity of mind. Reincarnation- possible fear soul getting lost in

Culture

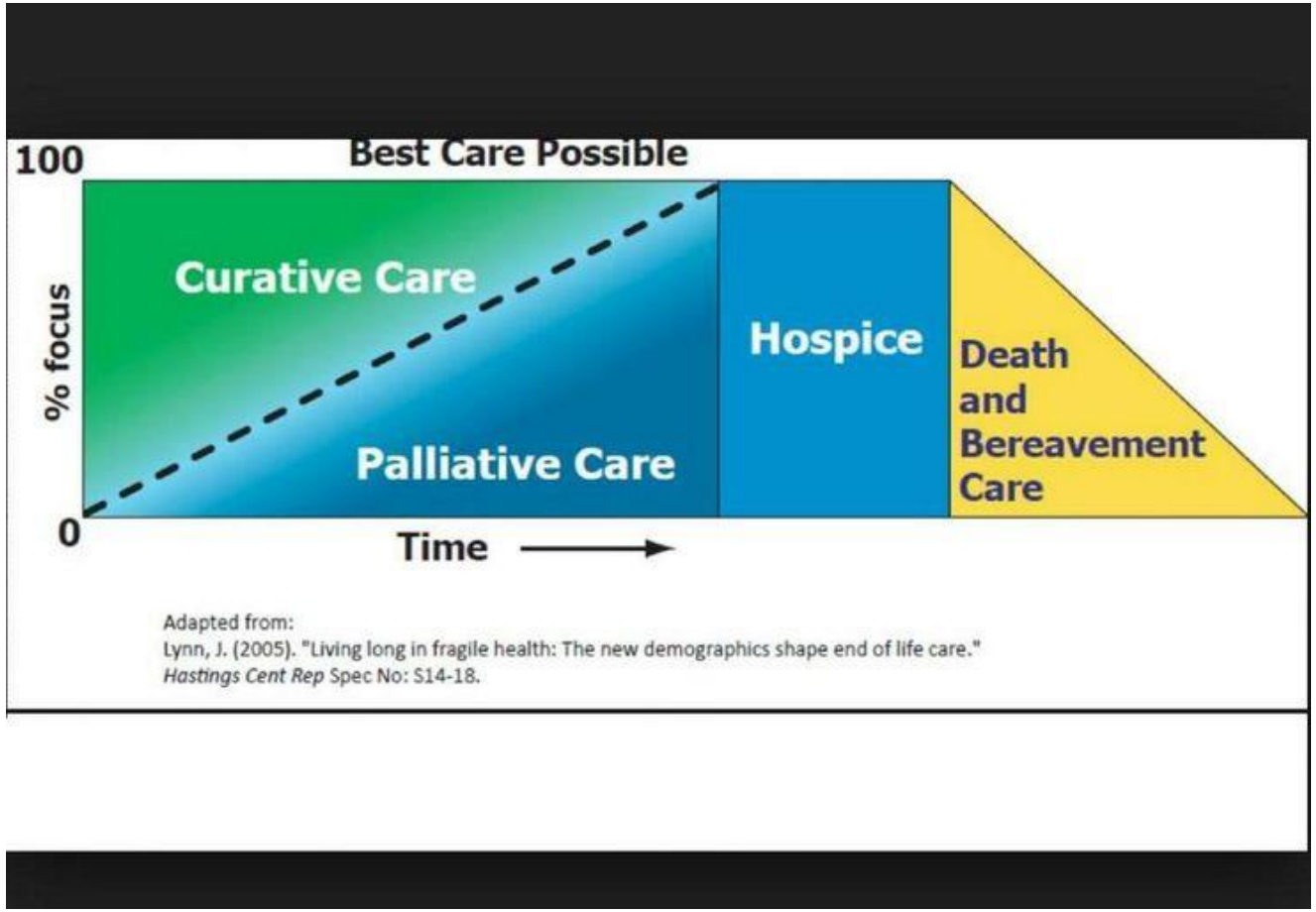
- Review of 33 studies of racial and end of life decision making

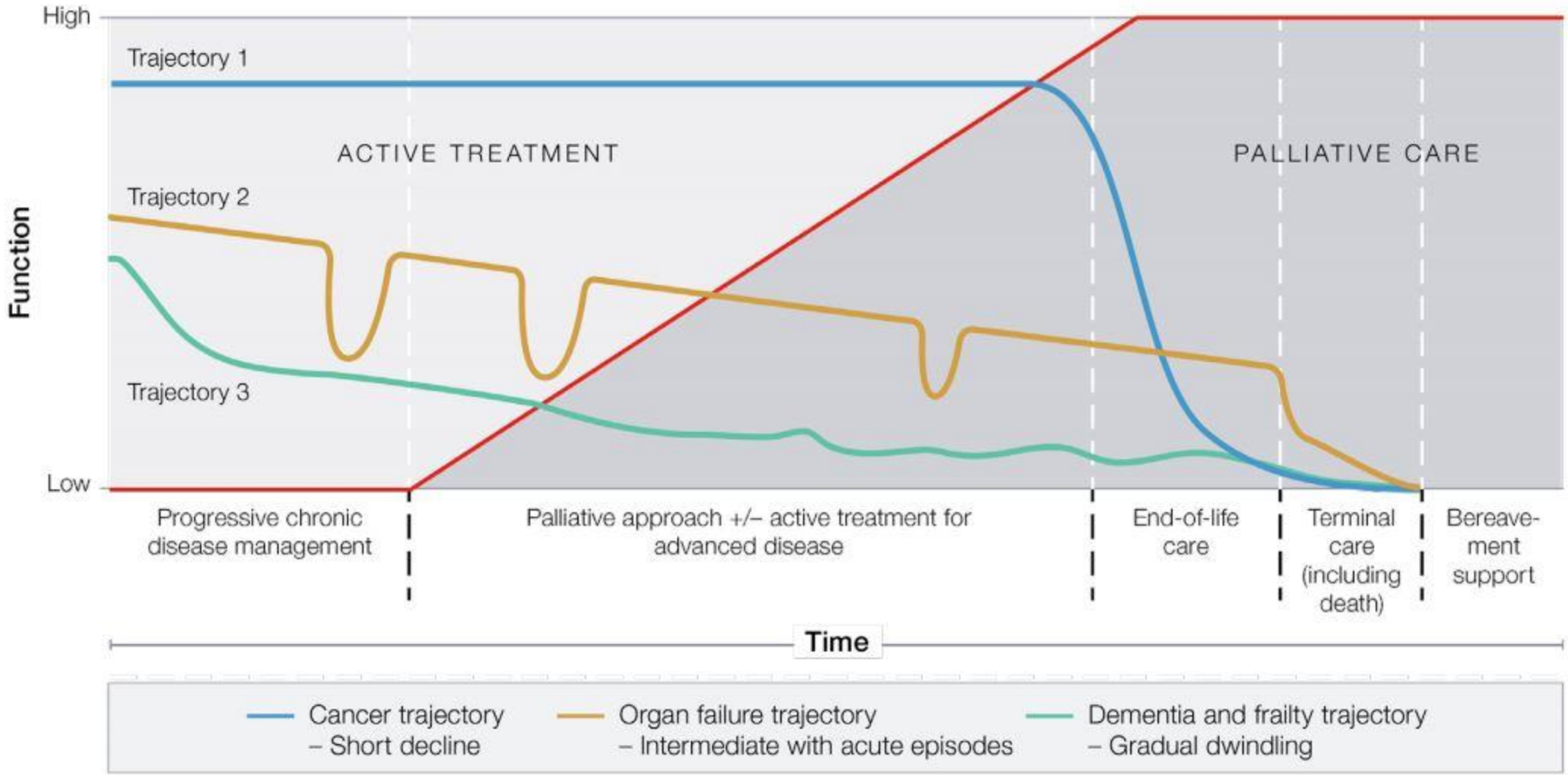
- Kwak, J., Gerontologist 45, no. 5 (2005):643-41.

Bouvia (California Court of Appeal, 2nd District, 1986)

- Reaffirmed the right of a competent adult to refuse medical treatments, including life-sustaining treatments even if not considered terminally ill.

Palliative Care

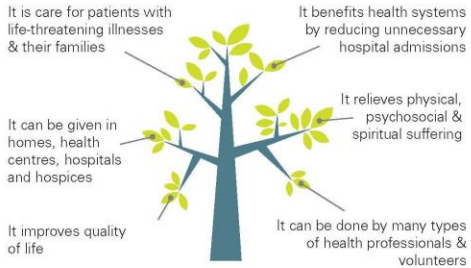



High
Low
Function
Trajectory 1
Trajectory 2
Trajectory 3
ACTIVE TREATMENT
PALLIATIVE CARE
Progressive chronic disease management
Palliative approach +/– active treatment for advanced disease
End-of-life care
Terminal care (including death)
Bereave-ment support
Time
Cancer trajectory – Short decline
Organ failure trajectory – Intermediate with acute episodes
Dementia and frailty trajectory – Gradual dwindling

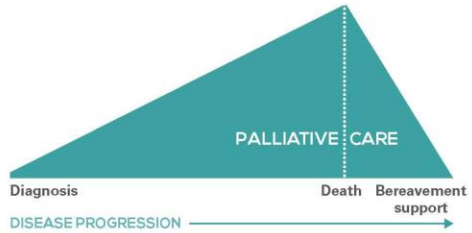
World Health Organization

IMPROVING ACCESS TO PALLIATIVE CARE

WHAT IS PALLIATIVE CARE ?



WHEN IS PALLIATIVE CARE NEEDED ?



WHO NEEDS IT ?

Of the **40 million** people who need palliative care each year:

39% have **Cardiovascular diseases**

34% have **Cancer**

10% have **Chronic lung diseases**

6% have **HIV/AIDS**

5% have **Diabetes**

WHAT ARE THE GAPS ?

86% of people who need palliative care do not receive it

83% of the world's population lack access to pain relief

98% of children needing palliative care live in low and middle income countries

WHAT ARE THE BARRIERS ?

Poor public awareness of how palliative care can help

Cultural & social barriers, such as beliefs about pain and dying

Insufficient skills and capacities of health workers

Overly restrictive regulations for opioid pain relief

WHAT CAN COUNTRIES DO?

Implement the 2014 World Health Assembly Resolution 67.19 on palliative care, by:

INTEGRATING PALLIATIVE CARE INTO NATIONAL HEALTH POLICIES

Revise laws & processes to improve access to opioid pain relief

Include palliative care in the training for health workers

Provide palliative care services, including through primary health care centres and homes

WHO/NMH/NVI/15.5

Palliative Care when to refer

- Life limiting illness, 4 high risk chronic conditions, dementia, pressure ulcers, dysphagia, chf, copd, end stage renal or liver, cancer…
- Labs- albumin <2.5, creat >2, inr >2, bilirubin >2, PSA>10, CA125 >35,
- 2 hospitalizations in 6 months, 2 urgent admissions in 12 months, SNF admission
- polypharmacy
- Functional changes- falls, ADL assistance, sentinel events

Helpful Links for the Primary Care

- Billing- Advance Care Planning (cms.gov)
- Healthynh.org
- Service Link - Welcome | ServiceLink (nh.gov)
- Ask about Veteran status- Refer to VA for additional benefits
- Address Goals of Care - VitalTalk
- SI-Clinician-Reference-Guide.pdf (instituteforhumancaring.org)
- Respectingchoices.org
- NH Laws - Chapter 137-J WRITTEN DIRECTIVES FOR MEDICAL DECISION MAKING FOR ADULTS WITHOUT CAPACITY TO MAKE HEALTH CARE DECISIONS (state.nh.us)

- www.Findhelp.org
- https://www.communityresourcefinder.org/
- https://www.alz.org/
- Home – EthnoMed
- Can the Patient Decide? Evaluating Patient Capacity in Practice -- American Family Physician (aafp.org)
- Probate Division | New Hampshire Judicial Branch (nh.gov)