Advanced Care Planning Healthcare Decision

CMSNE Public Policy Committee - 2022-2023

CMSA Conference June 27-30 - Driving Solutions Driving Change Las Vegas, NV

CMSA™ Case Management Society of America

New Hampshire Advanced Directives DPOA/Living Will

NH enacted Senate Bill (SB74) which altered the authority to an agent under the DPOA. Prior to this law, an agent had to be granted specific powers regarding healthcare decisions on the patient's behalf. The current law grants a DPOA the authority to any and all health decisions. Unless expressively limited by the DPOA. The POLST allows the agent to permit experimental treatment and Physician orders for life-sustaining measures. A POLST may include a DNR/DNI or Do Not Transport In NH if established by medical consensus and not by legislation. FHC (healthynh.org) Foundation for Healthy Communities NH.

Rhode Island Advanced Directives and Legislation

In Rhode Island, the discussion of advanced directives has been challenging there are several ways a patient can make their wishes known. All of the tools in RI are voluntary. People considering end-of-life discussions should speak with their physician to understand medical procedures, side effects, benefits, and limitations, with a lawyer to understand the legal issues and their family for support. Rhode Island allows for Living wills which allow a physician to instruct their physicians to withhold or withdraw life-sustaining procedures in the event of terminal conditions. The second document is a Durable Power of attorney for health care which allows the agent for the patient in a legal directive a physician, healthcare provider, and medical personnel may rely on these forms for medical decisions. A third option is a medical order to maintain life-sustaining measures. The final decision in Rhode Island is to determine if a person wishes to donate organs for the purpose of life-sustaining measures. Advance Directives: Department of Health (ri.gov)

Maine Advanced Healthcare Planning

In Maine the medical doctor determines what level of medical intervention you would like. The physician assists the patient to complete a POLST that becomes part of the medical file. The patient determines organ donation. Maine has a comprehensive advanced directive booklet that contains POA, Healthcare Agent it determines what powers that person has and can appoint the person as your guardian. Code status and MD to carry out your wishes and a second MD if your PCP cannot carry out wishes. **Advance Directive | Maine Health**

National Movement for Unified POLST Documentation

The National POLST Form was created because having a single form will make it easier to:

- Honor patient treatment wishes throughout the US
- Conduct research and quality assurance activities to improve the POLST form
- Educate about POLST so it is properly used everywhere.

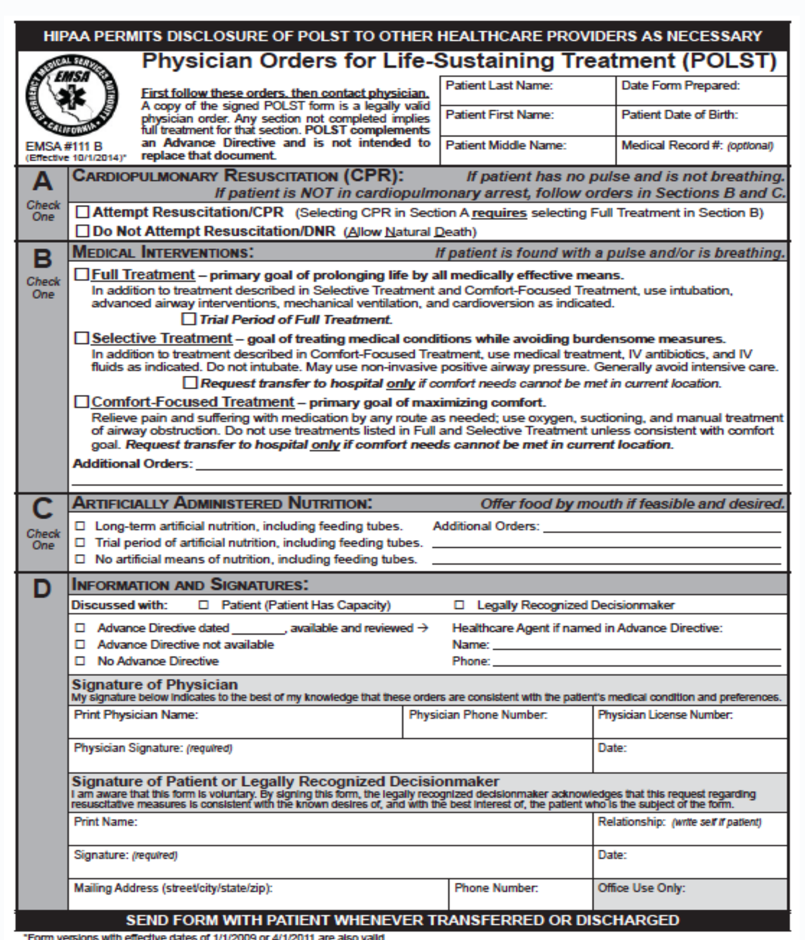
What is a POLST?

A POLST communicates your wishes as medical orders, and so is prepared together with your doctor who will sign it. POLSTs have different names in different states, but all have the force of medical orders. POLSTs are specifically for the seriously ill or frail. POLSTs can travel with you and are honored by emergency medical technicians.

POLST = Portable Medical Orders. Different states use different names such as POLST, POST, MOLST, MOST, etc. for their programs.

POLST is for people who are seriously ill or have advanced frailty. If you are healthy, an advance directive and organ donation for you. POLST forms and advance directives are both parts of advance care planning *but* they are not the same.

POLST forms must be filled out and signed by the health care provider. When you need a prescription, you go to your provider who writes or types an order for your prescription and signs it. POLST is a medical order so it is the same: you need to go to your healthcare provider who will write out the POLST and sign it. The difference with POLST is that you should have a good talk with your provider about what you want considering your current medical condition: What is likely to happen in the future? Treatment options? You'll also be asked to sign your POLST form.



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA (Emergency Medical Services Authority • California)

EMSA #111 B (Effective 10/1/2014)*

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A Check One — **Cardiopulmonary Resuscitation (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B Check One — **Medical Interventions:** *If patient is found with a pulse and/or is breathing.*

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only** if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.** Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: ____

C Check One — **Artificially Administered Nutrition:** *Offer food by mouth if feasible and desired.*

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: ____

☐ Trial period of artificial nutrition, including feeding tubes.

☐ No artificial means of nutrition, including feeding tubes.

D — **Information and Signatures:**

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated ____, available and reviewed → Healthcare Agent if named in Advance Directive:

☐ Advance Directive not available Name: ____

☐ No Advance Directive Phone: ____

Signature of Physician

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

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Mailing Address (street/city/state/zip):	Phone Number:	Office Use Only:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid

POLST forms tell other providers what you want. During a medical emergency, if you can talk, providers will ask you what you want. POLST forms are used only when you cannot communicate and you need medical care. When that is the situation, the POLST form orders providers to give you the treatments you chose.

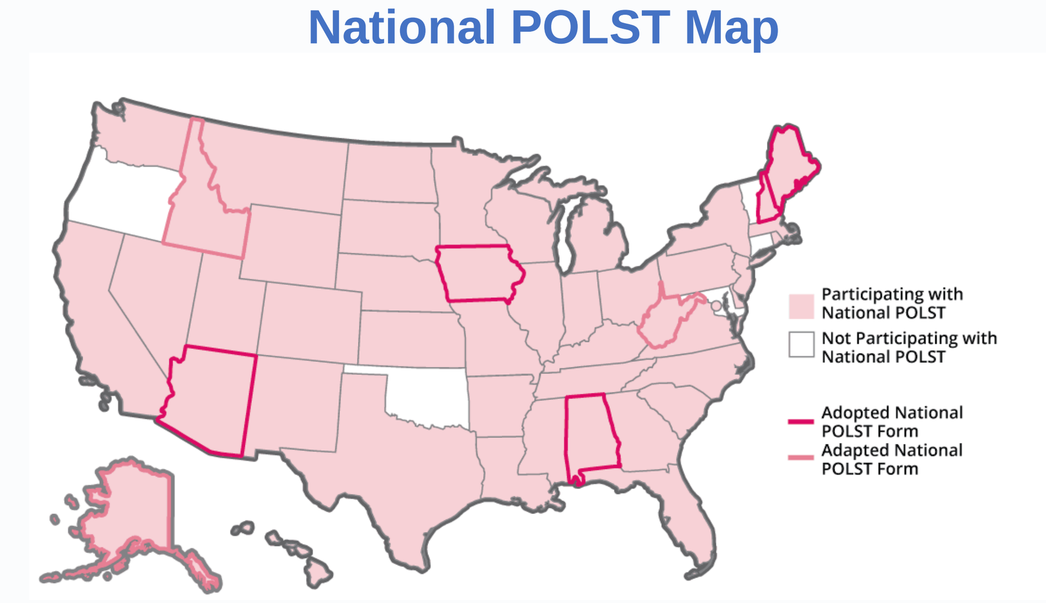
POLST forms are out-of-hospital medical orders. This means that they are medical orders that travel with you. Wherever you are, your POLST form tells health care providers what treatments you want and your goals of care, even if you transfer from hospital to nursing home, back to your home, or to hospice or another setting.

POLST is voluntary. You make the choice about having a POLST form: you should never be forced to have one! If you are healthy, however, your provider may choose not sign a POLST form for you since it was designed for people who are seriously ill or have advanced frailty (some state laws do not allow providers to sign a POLST form unless you are seriously ill or have advanced frailty).

Advance Directives: POLST's give specific directions about treatments during an emergency if you cannot speak for yourself. However, POLSTs do not appoint someone to speak on your behalf (surrogate or health care agent) which Advance Directives generally do. In a POLST, you specify exactly what you want and don't want and for how long. They have the force of medical orders and must be honored by emergency medical technicians (EMT's). EMT's cannot honor advance directives or medical powers of attorney. Once emergency personnel have been called, they must do what is necessary to stabilize a person for transfer to a hospital, both from accident sites and from a home or other facility. After a physician fully evaluates the person's condition and determines the underlying conditions, advance directives can be implemented.

Do Not Resuscitate (DNR's): A do-not-resuscitate order, or ***DNR*** order, is a medical order written by a doctor. It instructs healthcare providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating. If presented, it will be honored by EMT's. A POLST has the option of specifying DNR but also makes provision for your choices around resuscitation and other types of treatment such as feeding tubes and mechanical ventilation.

National POLST Map



Connecticut Advanced Directives

Connecticut uses Living Will or a healthcare representative and asks a number of questions regarding healthcare decisions for determining the healthcare representative. Each document Living will and health care representative are notarized and required two witnesses to complete the document legally. These two forms are combined with a MOLST for advanced lifecare planning. In Connecticut the combined advance directive. The form of a healthcare agent and living will are further combined with a conservator for financial oversite. The right to make decision document is given to patients and families to assist with making sure a patient has the right information to make a healthcare decision.

- What treatments may help you?
- How each treatment may affect you?
- How can it help you?
- What if any serious problems or side effects the treatment can cause?
- What may happen if you decide not to receive treatments?

ABA Commission on Law & Aging Consumer Tool Kit www.abanet.org/aging/toolkit/abaaging@abanet.org

Massachusetts Advanced Life Care Planning

In MA it is recommended to use The Conversation project The Conversation Project - Have You Had The Conversation? To begin the discussion of advanced care planning or go to honoring choices and discover the three steps to decision making 1.Choose a Health care proxy 2. Write down your care directives 3. Talk with your PCP about choices. www.honorchoicemass.com. The healthcare proxy and the MOLST are the only recognized documents in MA

Vermont Advanced Directives

Vermont uses a form called DNR/COLST same form as a POLST but called Clinician orders for life-sustaining measures. In Vermont, a clinician is defined as a medical Doctor, Osteopathic Doctor, or Nurse Practitioner to speak with the patient and determines life-sustaining measures. https://vtlawhelp.org/advance-directives#

The government website encourages Vermont residents to register their advanced directives and once done, the resident will receive reminders each year to change or confirm the directives already in place. When an advanced directive isn't filed, healthcare providers are required to follow the most recent directive available regardless of the date. Providers are given access to the registration website which enables them to see a patient's wishes in the event there is no copy immediately available. This registration process is also what makes the state different from others. Allowing providers to have central access to the advance directive allows for decisions to be made in the patient's best interest

CMSNE Public Policy Committee 2022-2023

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