Advance Care Planning

Condensed Advance Directive Instructions
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Objectives

1. Understand the need to support individuals with advance care planning during COVID-19
2. Understand how to create complete advance care planning documents
3. Understand witnessing requirements and process
4. Sending documents for upload into Epic for the healthcare team’s awareness
Advance Care Planning

Advance care planning (ACP) is an ongoing process in which patients, their families, and their health care providers reflect on the patient’s goals, values, and beliefs, discuss how they should inform current and future medical care, and document plans.
Why Now?

- High risk populations that do not have any Advance Care Planning competed
- Opportunity to empower people
- Support families and loved ones
- Avoid unwanted acute care
Who should be involved in a conversation?

- All patients that don’t have Patient Advocate designated and treatment preferences clearly documented.
- Individuals with capacity to make decisions
- Family and loved ones
Introducing the Topic

“As you know, there is a lot of uncertainty about the COVID virus right now, but one thing we can control is the opportunity to share your wishes, if you were to become ill. We hope that doesn’t happen, but it’s more important than ever to ensure that your loves ones and healthcare team know what you want so we can honor your wishes. I want to spend a little time getting to know what is most important to you and putting some plans in place to make this possible.”
Communication Skills

Active Listening Skills

- Ask open-ended questions
- Request clarification
- Be attentive
- Summarize
- Paraphrase
- Reflect feelings
- Be attuned to feelings
- Ask probing questions
Durable Power of Attorney for Health Care  
Spectrum Health

L. hereby appoint  
(Patient Advocate)

as my attorney in fact (herein called patient advocate) with the following power to be exercised in my name and for my benefit, including, but not limited to, making decisions regarding my care, custody or medical treatment. This power of attorney has effect only if I become unable to participate in treatment decisions.

If the E. at individual unable, unwilling or unavailable to serve as my patient advocate, then designate

residing at  
(Designation of Alternate Patient Advocate)

at  
(Designation of Alternate Patient Advocate Address)

I have instructed my Patient Advocate(s) concerning my wishes and goals in the case of:  
- Ongoing treatment
- Life-sustaining treatment
- Cessation of treatment

With respect to other personal care, my advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person, including, but not limited to:

- To have access to and control over my medical and other personal information.
- To employ and discharge physicians, nurses, therapists and any other care providers, and to pay them reasonable compensation.
- To execute waivers, medical authorizations and such other approval as may be required to permit or authorize care that I may need or to discontinue care that I am receiving.
- To prepare and sign all documents or other agreements in connection with treatment decisions.
- My advocate shall be guided in making such decisions by what I have told my advocate about personal preferences concerning such care. Some of these preferences may be recorded below.

Attorney-in-Fact or Designee:

I hereby appoint [Name] at [Address] to serve as my patient advocate.

Ttl. Attny:  
Name:  
Address:  
Phone:

Authorization
DO NOT RESUSCITATE (DNR) - MICHIGAN OUT-OF-HOSPITAL
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DO-NOT-RESUSCITATE:

The purpose of this policy is to provide a guideline to prehospital providers, who under certain circumstances may accommodate patients who do not wish to receive or may not benefit from cardiopulmonary resuscitation. This policy is stated in accordance with Public Act 366 of 1978, as amended, as well as Act 192 and 101 of the Public Acts of 1978 and amendments, effective February 4, 2014. This policy is intended to facilitate kind, humane, and compassionate service for patients who have executed a valid “Do-not-resuscitate order” under the aforementioned Acts.

1. Definitions

A. Attending Physician – means the physician who has primary responsibility for the treatment and care of a declarant.
B. Declarant – means a person who has executed a do-not-resuscitate order, or on whose behalf he/she has executed a do-not-resuscitate order.
C. Do-not-resuscitate order – means a document executed under Public Act 190 of 1996, as amended, directing that if an individual suffers cessation of both spontaneous respiration and circulation in a setting outside of a hospital, resuscitation will NOT be initiated.
D. Do-not-resuscitate Identification Bracelet or Identification Braclet – means a wrist bracelet that bears the requirements of Act 190 and worn by a declarant while a do-not-resuscitate order is in effect. The identification bracelet shall be imprinted with the words “DO NOT RESUSCITATE ORDER”, the name and address of the declarant, and the name and telephone number of the declarant’s attending physician, if any.
E. Guardian – means a person who has been designated as a guardian of the person or property of a minor or a legally incapacitated individual under a parental or other legal appointment and includes a limited guardian as described in Sections 5205, 5206, and 5306 of the estates and protected individuals code, 1998 PA 386, MCL 720.1109(7).
F. Order – means a do-not-resuscitate order.
G. Patient Advocate – means a person designated to make medical treatment decisions for a patient under Sections 5505 to 5515 of the estates and protected individuals code, 1998 PA 386, MCL 720.1109(7).
H. Vital Signs – means a pulse or evidence of respiration.

Pre-Medical Control

MFE/EMS/SPECIALIST/PARAMEDIC

2. Procedures

A. A do-not-resuscitate order is applicable to all prehospital life support agencies and personnel. A do-not-resuscitate order may be executed by an individual 18 years of age or older and of sound mind OR by an individual 18 years of age or older and of sound mind, and adherent of a church or religious denomination whose members depend upon...
Durable Power of Attorney for Health Care (DPOAH)

- A legal document that allows an individual to declare who may speak for them when they cannot speak for themselves.

- The DPOAH document must meet specific requirements in order to be used to activate a DPOAH or designated patient advocate.

- Needs to be reviewed for completeness prior to scanning into Epic and activating a patient advocate.
Advance DPOAH Requirements

Review Signature Components

Review of the DPOAH document must be completed to ensure that all components are complete to allow legal activation of the patient advocate when the patient has lost decision making capability. These components are:

- Patient signature
- Two witness signatures
- Patient Advocate acceptance signature
- Dates (patient and witness signature dates are matching) *the witness signatures indicate they watched the patient sign the DPOAH form

Review Decision Making Authorities Granted

State of Michigan requires end of life decision making authority to be specifically granted in DPOAH documents. Scan document for this language around making decisions that would allow the individual to pass away. If a Making Choices Michigan document is used look for the boxed section at the top of page 3 to be completed.
Designating Patient Advocate

Demographic information – Green Box
- 2 patient identifiers
- Name Patient Advocate
- Second Patient Advocate (Recommended)

End of Life Authority – Red Circle
- CRITICAL
- Must check this box to grant authority

I, Rena Ruehle, 12-1-1954, hereby appoint Jen Eriks, residing at 300 Happy Drive Grand Rapids, MI 49503, to serve as my patient advocate.

I have instructed my Patient Advocate(s) concerning my wishes and goals in the use of life sustaining treatment - such as, but not limited to: ventilator (breathing machine), cardiopulmonary resuscitation (CPR), nutrional tube feedings, intravenous hydration, kidney dialysis, blood pressure or antibiotic medications—and hereby request that the Patient Advocate(s) express permission to help me achieve my goals of care. This may include the starting, or stopping treatment(s) which, with such consent, will be necessary to execute my wishes. Making my death decisions and treatment choices to provide comfort or pain relief shall not be withheld or withdrawn.

I expressly authorize my Patient Advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my death.

With respect to other personal care, my advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person including, but not limited to:
(If any of the following do not apply, I may cross them out and place my initials next to the item.)
Optional Items

With respect to other personal care, my advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person, including, but not limited to:
(If any of the following do not apply, I may cross them out and place my initials next to the item.)

A. To have access to and control over my medical and other personal information.
B. To employ and discharge physicians, nurses, therapists and any other care providers, and to pay them reasonable compensation.
C. To execute waivers, medical authorizations and such other approval as may be required to permit or authorize care that I may need or to discontinue care that I am receiving.
D. My advocate shall be guided in making such decisions by what I have told my advocate about personal preferences regarding such care. Some of those preferences may be recorded below.

Recording any of your preferences in the space below is optional.

My wishes concerning care are as follows, including any religious beliefs that prevent an examination by a doctor, licensed psychologist, or other medical professional.

<table>
<thead>
<tr>
<th>Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would like last rights</td>
</tr>
</tbody>
</table>
Signatures

Durable Power of Attorney for Health Care

This document is to be treated as a Durable Power of Attorney and shall survive my disability or incapacity.

This Advance Directive includes the following sections: Patient Advocate acceptance; Treatment Preferences (Goals of Care).

This document is signed in the state of Michigan. It is my intent that the laws of the state of Michigan govern all questions concerning its validity, the construction of its provisions and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.

I voluntarily sign this Durable Power of Attorney for Healthcare after careful consideration. I understand its meaning and accept its consequences.

616-915-1111

Witnesses:

I know this person to be the individual identified as the "individual" signing this form. I believe him or her to be of sound mind and at least eighteen (18) years of age. I personally saw him or her sign this form, and I believe that he or she did so voluntarily and without duress, fraud, or undue influence.

By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not the Patient Advocate or alternate Patient Advocate appointed by the person signing this document.
- Not the patient’s spouse, parent, child, grandchild, sibling or presumptive heir.
- Not listed as a beneficiary of, or entitled to, any gift from the patient’s estate.
- Not directly financially responsible for the patient’s health care.
- Not a health care provider directly serving the patient at this time.
- Not an employee of a health care place or insurance provider directly serving the patient at this time.

Names and Addresses of Witnesses:

WITNESS ONE
Name: Mickey Disney
Signature:
Address: 123 Main St, Grand Rapids, MI 49503

WITNESS TWO
Name: Walt Disney
Signature:
Address: 123 Main St, Grand Rapids, MI 49503

- Person’s signature must be witnessed
- Witness is attesting that person is
  - Of sound mind
  - 18 years of age
  - Signing voluntarily without duress, fraud, or undue influence
- Witnesses may not be
  - Minors
  - Patient advocate or family
  - Beneficiary
  - Health care team member or employee
Video Witnessing – During Visitor Restrictions

- Please check with your facility
  - Contact Jen Eriks and/or Rena Ruehle if you would like more information

- Video witnesses
  - 2 individuals witness via video
  - 2 staff members observe the video witness and document attestation
  - Sign, print name, date for each staff member
  - Write ‘video witness’ in signature line of witness, witness name, and address
Can be obtained later, even after the person has lost decision making capacity.

Recommend not trying to secure acceptance signatures at this time.
Treatment Preference (Goals of Care)

- Understand where the balance lies between length of life and quality

- How that balance might change if they were near to the end of their life
Many individuals have thought about situations that are unacceptable

Please mark any items that the person feels would be unacceptable

May be asked why is this important, “We hope that you never are in these situations, but if you are, we would want to know what you believe to be unacceptable to you so we can provide care to keep you comfortable rather than care that is focused on prolonging your life”
Treatment Preferences (Goals of Care)

Values and experiences that are important to me:

- Communicate with my family and friends
- Activities with my family and friends
- Remain independent for as long as possible
- Participate in church services

- Communicates to everyone what is important to live well
Treatment Preferences (Goals of Care)

- Encourage use of decision aids provided from Respecting Choices®
- Mindful of personal bias
- Document preferences for each decision
- Out Of Hospital Do Not Resuscitate document will need to be completed if the patient does not want to receive CPR

NOTE: This is not a "Do Not Resuscitate" (DNR) Order, which is a separate legal document. Talk with your personal healthcare provider if you would like a DNR Order.
Respecting Choices® Decision AIDS

Ventilator
- A tube goes into your mouth or nose down your throat and into your windpipe. The tube is connected to a machine called a ventilator.
- Pushes oxygen into your lungs to help you breathe.
- May allow you to recover from a breathing problem (like pneumonia) from your illness. May allow you to live longer.
- With this tube, you cannot speak or swallow. You will need medicine to help you stay calm. You will need to be in the intensive care unit (ICU).
- You may not be able to get off the ventilator. You may need long-term ventilator care. Your health may worsen and other problems may occur.
- Your Values: You want the chance to extend the length of your life.

Non-Invasive Airway (like BiPAP)
- A tight-fitting mask covers your nose and mouth. The mask is connected to a machine.
- Pushes oxygen into your lungs to help you breathe.
- May allow you to recover from a breathing problem (like pneumonia) from your illness. May allow you to live longer.
- The tight-fitting mask can cause skin irritation. The mask will make it hard to talk or eat. You may need medicine to help you stay calm. It is likely you will need to go to the hospital.
- Medicines may make you drowsy. Oxygen may dry your mouth and nose.

Comfort-Focused
- Efforts to keep you comfortable, like:
  - Medication and oxygen for breathlessness
  - Physical and emotional support
  - Helps control shortness of breath, anxiety, and fear
- AVOIDS machines. May allow you to be kept comfortable.

Comfort Feeding
- You are able to eat or drink enough by mouth to maintain nutrition. This decision aid will help you consider options for feeding and your personal values. You may change your choice at any time. Whatever your choice, you will be kept as comfortable as possible.

Cardiopulmonary Resuscitation (CPR) Decision Aid
- A test of your immunity.
- What is it? For you, it means you are not able to breathe on your own.
- May need it: Yes
- What does it do? You will be put on a ventilator to breathe for you.
- What are the benefits? You may be able to breathe more comfortably.
- What are the short-term burdens? You may need to be on the ventilator for a long time. You may need to stay in the intensive care unit.
- What are the long-term burdens? You may need long-term ventilator care. Your health may get worse and other problems may occur.
- Which option best matches your values? You are willing to take some risks.

Long-Term Tube Feeding Decision Aid
- Cardiopulmonary Resuscitation (CPR) Decision Aid
- For people with underlying serious illness (like heart or lung disease or cancer) facing a decision about the use of long-term tube feeding. This decision aid will help you consider options for feeding and your personal values. You may change your choice at any time. Whatever your choice, you will be kept as comfortable as possible.

Comfort Feeding
- You are able to eat or drink enough by mouth to maintain nutrition. This decision aid will help you consider options for feeding and your personal values. You may change your choice at any time. Whatever your choice, you will be kept as comfortable as possible.
Respecting Choices® Decision Aids

Using Decision Aids During
Shared Decision-Making
Conversations

Sandra Schellinger, MSN, RN, NP-C
Senior Faculty Consultant
Respecting Choices
A Division of C-TAC Innovations

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Out of Hospital DNR

- Explain that with the election of no CPR, there is some additional paperwork you can help them complete so others are aware of their wishes.

- Total of 6 pages

- Page 3 requires the physician name and decision maker signature.

- If the patient cannot make their own decisions, there is an option for the enacted Patient Advocate or Guardian to sign instead.
Out of Hospital DNR

- Page 4 requires witness and physician signature
- Witness signatures must be dated the same as patient signature
- Physician signature date does not have to match patient/witness signature date
- Pages 5 and 6 are for those patients who, due to a church or religious denomination, chose not to be seen by a physician
Follow-Up

- OOH DNR Bracelet
- Ensure all documents are in your facilities medical record
- Share documents with the Patient Advocate and other family members
- If documents are missing signatures, create a timely plan to obtain these
- Post visit documentation
- For scanning into Epic, email all documents to advancecareplanning@spectrumhealth.org. Even incomplete documents show the patient’s intent and can possibly be completed by another staff member when they come to the hospital.
Support and Resources

- Rena Ruehle: Cell 616-915-1132 Rena.Ruehle@spectrumhealth.org
- Jen Eriks: Cell 616-401-1388 Jenniferd.Eriks@spectrumhealth.org
- ACPP Dept number: 616-774-7615 advancecareplanning@spectrumhealth.org
- Center to Advance Palliative Care: https://www.capc.org
- Ariadne Labs: https://www.ariadnelabs.org/
- Vital Talk: https://www.vitaltalk.org/
- Conversation Project: https://theconversationproject.org/
- Prepare for your Care: https://prepareforyourcare.org/welcome
- ACP Decisions: https://acpdecisions.org/
- Respecting Choices: https://respectingchoices.org/covid-19-resources/