# Demystifying Advanced Care Planning

October 20, 2021

Connected Care of Southeastern Mass

South Shore Health

# Introductions

# Disclaimer

South Shore Health

- The “Demystifying Advanced Care Planning” webinar is for informational purposes only, and does not constitute medical or legal advice.

# WebEx

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- Use the Chat function for asking questions during the presentation
- Presentation will be posted on SSH website this week
- Resources slide at the end of the presentation

# Agenda

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- Case Study: Mr. S
- Questions
- Advanced Care Planning Documents

# Case Study

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Mr. S is a 72-year-old retired school teacher, father of three, who raised his family on the South Shore. Mr. S is an active member in the local garden society as well as a regular contributor to a food pantry program. He is widowed, has three children, seven grandchildren, and enjoys spending time with his family. Other than elevated blood pressure and mild Parkinson's disease he had been relatively healthy and quite active.

# Case Study (cont'd)

Three years ago his children noticed mild memory loss. Mr. S was getting lost and forgetful, which required him to stop driving. Over the following six months, Mr. S moved in with one of his daughters due to more significant memory loss and confusion. His children did not feel he could live safely by himself any longer.

Two years ago he was diagnosed by a neurologist with dementia related to Parkinson's Disease. It became increasingly difficult for his family to care for him at home, and his children decided the best alternative for him was a memory loss unit at a nearby nursing home.

He has had significant progression of his dementia in the past 18 months with admissions to the hospital for episodes of confusion, combativeness, agitation and urinary tract infections. In addition to his cognitive decline, he has had difficulty swallowing and significant weight loss.

He is currently admitted to the hospital for the 11$^{th}$ time in 18 months. Mr. S is being treated for aspiration pneumonia and the medical team is concerned he will need to be intubated.

# Case Study (cont'd)

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The Palliative Care team at the hospital has been consulted, and is having a family meeting with Mr. S and his children.  Mr. S never discussed his ideas about care or his goals with his family, and is unable to participate in the discussion due to his illness. He does not have a signed health care proxy in place. His children have different ideas about what type of care they think their father would want.

# Questions

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- Who should have advanced care planning documents?
- When is the best time to think about advanced care planning?
- What documents should you have in place?
- If someone gets acutely ill, what documents should you have on hand?
- Where should you keep advanced care planning documents?

# Case Questions

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- When would have been a good time to have the discussions about Mr. S's wishes and goals of care?
- Who should have had these conversations?
- What specifically should have been discussed in these conversations?

# Advanced Care Planning Documents

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- MOLST:  Massachusetts Orders for Life Sustaining Treatment
- HCP: Health Care Proxy
- DPOA: Durable Power of Attorney
- Advance Directive:  ex. Five Wishes

# Massachusetts Orders for Life Sustaining Treatment (MOLST)

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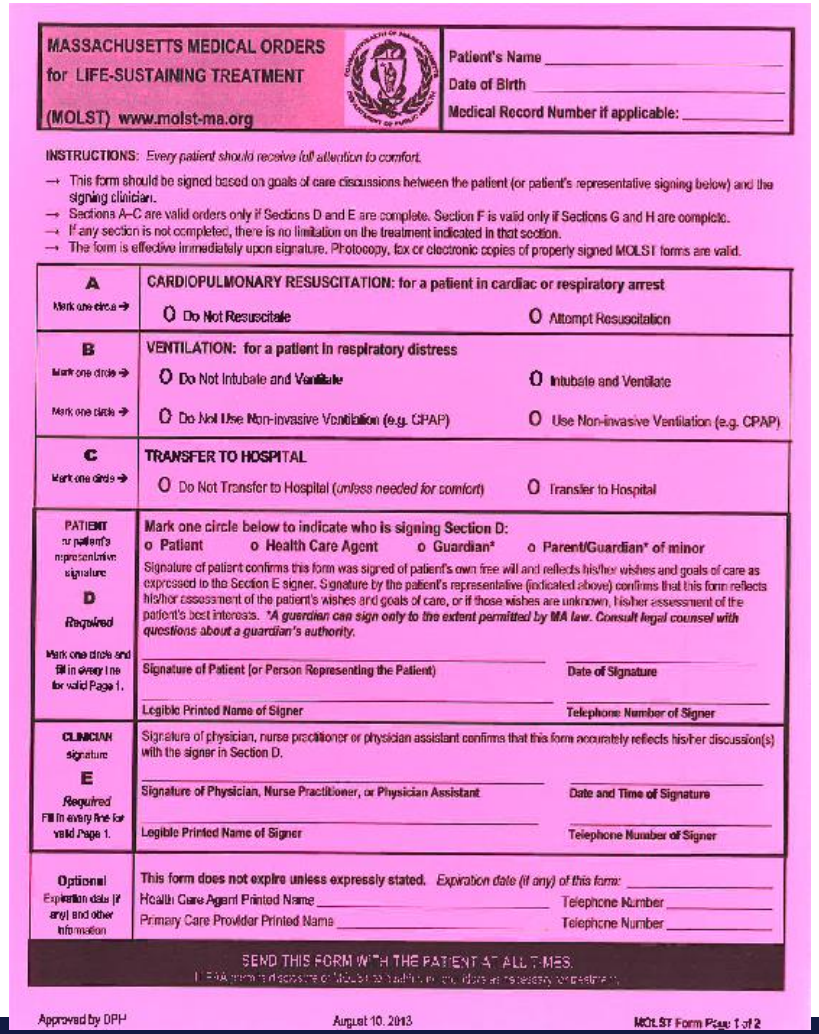
- MOLST: a **MEDICAL** document
- Provider (MD/DO, NP/PA)
- Orders for treatment



MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT (MOLST) www.molst-ma.org

Patient's Name _____
Date of Birth _____
Medical Record Number if applicable: _____

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

→ This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the signing clinician.
→ Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
→ If any section is not completed, there is no limitation on the treatment indicated in that section.
→ The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

**A** — Mark one circle →
**CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest**
O Do Not Resuscitate O Attempt Resuscitation

**B** — Mark one circle →
**VENTILATION: for a patient in respiratory distress**
O Do Not Intubate and Ventilate O Intubate and Ventilate
Mark one circle →
O Do Not Use Non-invasive Ventilation (e.g. CPAP) O Use Non-invasive Ventilation (e.g. CPAP)

**C** — Mark one circle →
**TRANSFER TO HOSPITAL**
O Do Not Transfer to Hospital (*unless needed for comfort*) O Transfer to Hospital

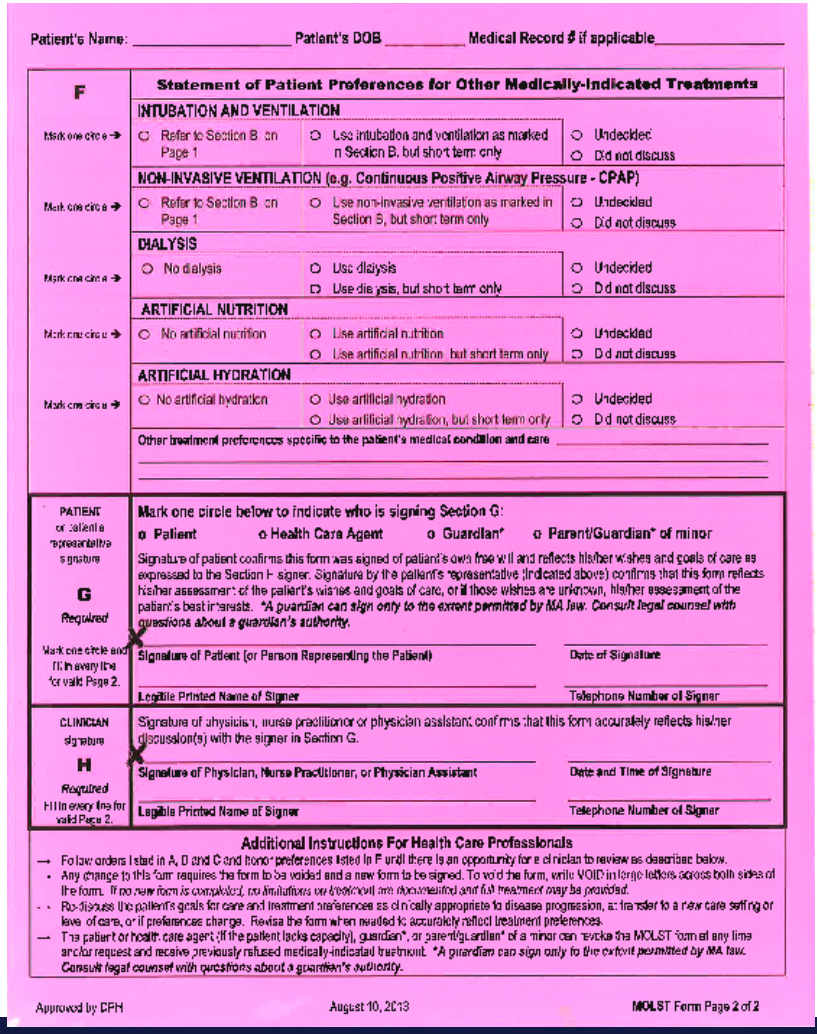
**PATIENT** or patient's representative signature **D** *Required*
Mark one circle and fill in every line for valid Page 1.
Mark one circle below to indicate who is signing Section D:
o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor
Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*
Signature of Patient (or Person Representing the Patient) Date of Signature
Legible Printed Name of Signer Telephone Number of Signer

**CLINICIAN** signature **E** *Required*
Fill in every line for valid Page 1.
Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.
Signature of Physician, Nurse Practitioner, or Physician Assistant Date and Time of Signature
Legible Printed Name of Signer Telephone Number of Signer

**Optional** Expiration date (if any) and other information
This form does not expire unless expressly stated. *Expiration date (if any) of this form:* _____
Health Care Agent Printed Name _____ Telephone Number _____
Primary Care Provider Printed Name _____ Telephone Number _____

SEND THIS FORM WITH THE PATIENT AT ALL TIMES

Approved by DPH August 10, 2013 MOLST Form Page 1 of 2



Patient's Name: _____ Patient's DOB _____ Medical Record # if applicable _____

**F** — **Statement of Patient Preferences for Other Medically-Indicated Treatments**

| | | |
|---|---|---|
| **INTUBATION AND VENTILATION** | | |
| Mark one circle → O Refer to Section B on Page 1 | O Use intubation and ventilation as marked in Section B, but short term only | O Undecided O Do not discuss |
| **NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)** | | |
| Mark one circle → O Refer to Section B on Page 1 | O Use non-invasive ventilation as marked in Section B, but short term only | O Undecided O Do not discuss |
| **DIALYSIS** | | |
| Mark one circle → O No dialysis | O Use dialysis O Use dialysis, but short term only | O Undecided O Do not discuss |
| **ARTIFICIAL NUTRITION** | | |
| Mark one circle → O No artificial nutrition | O Use artificial nutrition O Use artificial nutrition, but short term only | O Undecided O Do not discuss |
| **ARTIFICIAL HYDRATION** | | |
| Mark one circle → O No artificial hydration | O Use artificial hydration O Use artificial hydration, but short term only | O Undecided O Do not discuss |

Other treatment preferences specific to the patient's medical condition and care _____

**PATIENT** or patient's representative signature **G** *Required*
Mark one circle and fill in every line for valid Page 2.
Mark one circle below to indicate who is signing Section G:
o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor
Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section H signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*
Signature of Patient (or Person Representing the Patient) Date of Signature
Legible Printed Name of Signer Telephone Number of Signer

**CLINICIAN** signature **H** *Required*
Fill in every line for valid Page 2.
Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G.
Signature of Physician, Nurse Practitioner, or Physician Assistant Date and Time of Signature
Legible Printed Name of Signer Telephone Number of Signer

**Additional Instructions For Health Care Professionals**

→ Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.
- Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. If no new form is completed, no limitations are documented and full treatment may be provided.
- Re-discuss the patient's goals for care and treatment preferences as clinically appropriate for disease progression, a transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences.

→ The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*

Approved by DPH August 10, 2013 MOLST Form Page 2 of 2

# Health Care Proxy (HCP)

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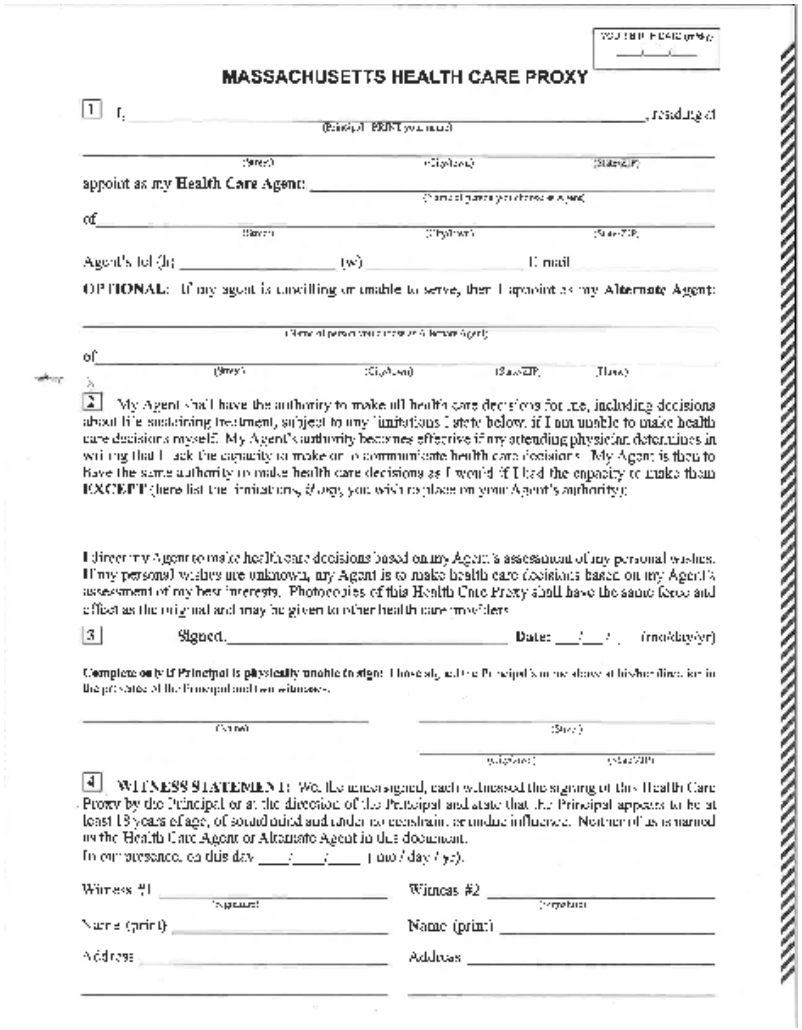
- Health Care Proxy:  a **LEGAL** document
- Designates who should speak for you should you become unable to speak for yourself



MASSACHUSETTS HEALTH CARE PROXY

1 I, _____, residing at

_____

appoint as my Health Care Agent: _____

of _____

Agent's tel (h): _____ (w) _____ E-mail

OPTIONAL: If my agent is unwilling or unable to serve, then I appoint as my Alternate Agent:

_____

of _____

2 My Agent shall have the authority to make all health care decisions for me, including decisions about life sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list any limitations you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

3 Signed: _____ Date: ___/___/___ (mo/day/yr)

**Complete only if Principal is physically unable to sign:** I have read, or the Principal's name above has/has directed in the presence of the Principal and two witnesses.

_____ _____

4 **WITNESS STATEMENT:** We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document.

In our presence, on this day ___/___/___ (mo/day/yr).

Witness #1 _____ Witness #2 _____

Name (print) _____ Name (print) _____

Address _____ Address _____

# Durable Power of Attorney (DPOA)

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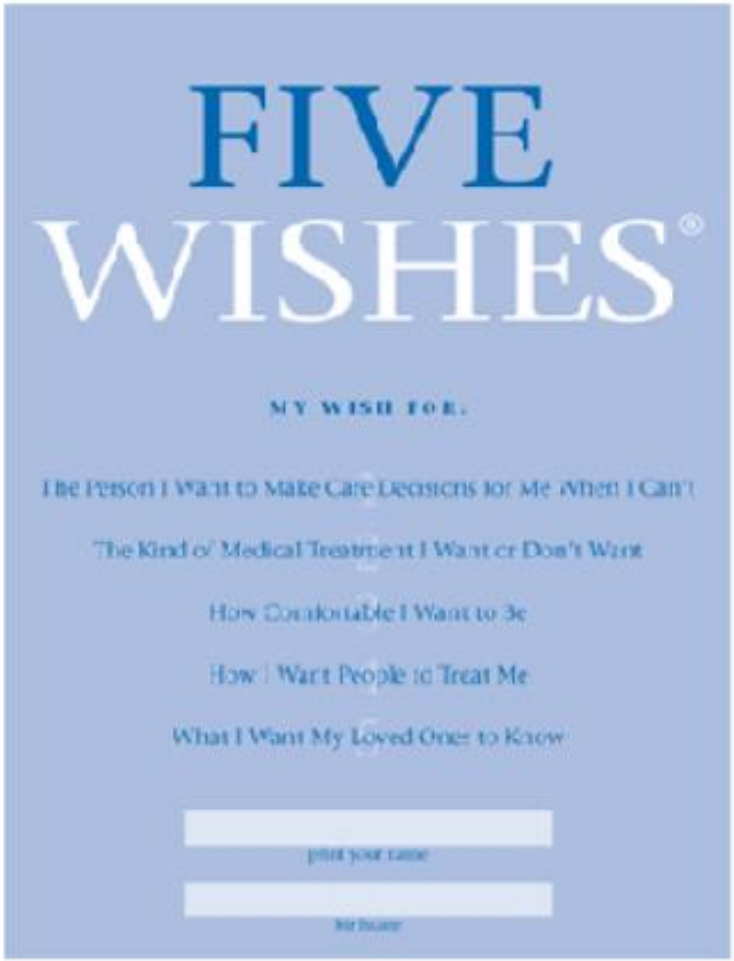
- Durable Power of Attorney (DPOA) is a **LEGAL** document
- Designates who can make financial decisions should you become unable to speak for yourself

# Five Wishes

- Five Wishes: a **LEGAL** document
- Example of an advance directive

- Five Wishes:
  - The person I want to make decisions for me when I can't
  - The kind of medical treatment I want or don't want
  - How comfortable I want to be
  - How I want people to treat me
  - What I want my loved ones to know



# Let’s Talk Turkey

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- South Shore Health is sponsoring a Let’s Talk Turkey campaign to educate the community, providers and staff, and their family members about advanced care planning documents
- November 2021
- MOLST, HCP

# Questions

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# Resources

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- www.honoringchoicesmass.com
- https://dfmassachusetts.org/wp-content/uploads/sites/6/2019/06/Massachusetts-Medical-Orders-for-Life-Sustaining-Treatment-Presentation.pdf
- www.fivewishes.org

# Thank You