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Advance Planning for Independence and Autonomy

February 15, 2018

Featured Speaker

David Hoffman, DPS, CCE

- Director, Bureau of Community Integration and Alzheimer's Disease, New York State Department of Health
- Clinical Professor, Health Policy, Management and Behavior, University at Albany School of Public Health

Learning Objectives

- Explain the difference between advance planning and advance directives
- List 3 benefits of advance planning
- Describe 2 examples of initiatives to change the approach to advance planning

History

- Nancy Cruzan, 25 years old
 - Motor vehicle accident resulted in a persistent vegetative state and necessitated a feeding tube to provide long-term care
 - Did not have advance directives in place - rehabilitation hospital refused to remove feeding tube at parents' wishes
 - Case brought to Jasper County court, Missouri state Supreme Court and US Supreme Court before it was ruled that the feeding tube could be removed

Federal Law

- Omnibus Budget Reconciliation Act of 1990 (H.R. 5835)
- Patient Self Determination Act of 1990 (H.R. 5067)



New York State Law

- New York State Health Care Proxy Law (1991)
- Chapter 197 of the Laws of 2008 (2008)
- Family Health Care Decisions Act (2010)



MOLST

NEW YORK STATE DEPARTMENT OF HEALTH **Medical Orders for Life-Sustaining Treatment (MOLST)**

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT _____

ADDRESS _____

CITY/STATE/ZIP _____

DATE OF BIRTH (MM/DD/YYYY) _____ Male Female **MOLST NUMBER (THIS IS NOT AN MOLST FORM)** _____

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)
 This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient's current medical condition, values, wishes and MOLST instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another unless a physician examines the patient, reviews the orders and changes them. MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician to fill out a MOLST form if the patient:

Advance Directives

- MOLST/POLST
- Health Care Proxy
- Living will



Key Definitions

- DNR: Do not resuscitate
- DNH: Do not hospitalize
- DNI: Do not intubate

Traditional Focus

- End of life
- Legal documents
- Lack of conversation
- Less emphasis on the process

Advance Planning

What is advance planning?

- Legal documents

AND

- Conversations with family, physicians, and others

Surrogate Decision Maker

Role:

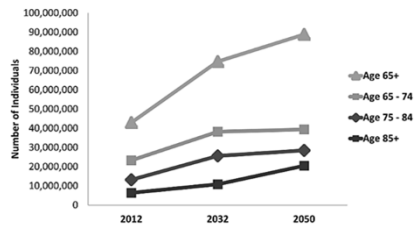
- To make the decision the patient would have made in the current circumstance, had they been able

Values

- Something I prize and cherish
- Publicly Affirm
- Act on consistently

The Numbers

The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050

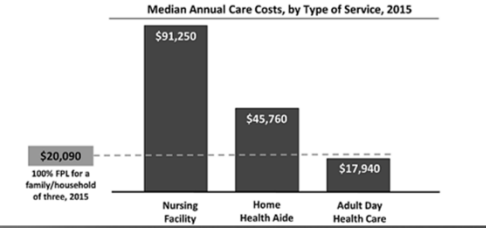


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Benefits of Advance Planning

- Individual
 - Increased likelihood of patients receiving end-of-life care according to their preferences
 - Decreased levels of unwanted life-sustaining medical treatments
 - Improvement in overall quality of life
 - Decreased discomfort and distress

Benefits of Advance Planning

- Caregiver/Family
 - Reduced symptoms of stress, anxiety, and depression for family members of patients with advance planning
 - Increased satisfaction with end-of-life care for deceased patient
 - Alleviated burden of decision making for patient
 - Focus on quality of Life
 - Improved financial security

Benefits of Advance Planning

- Healthcare system costs
 - Cost savings due to decreased wasteful spending attributed to providing unwanted care
 - Health costs are on average fewer for those with advance planning
 - Reduced provider distress

Best Practice Recommendations

- Thinking beyond just the documents
 - Complex advance planning interventions may be more effective in meeting patient preferences than written documents alone
 - Life and long term care planning
- Transition from legal transaction to communications approach

Best Practice Recommendations

- Moving beyond healthcare setting and into the community
- Many people capable of facilitating and supporting the discussion
 - Health-care professionals
 - Trained non-physician facilitator
 - Social workers
 - Family and friends

Best Practice Recommendations

- Timing
 - Never too early
 - Any stage of life
 - Process– not a single event
- Life planning



Recognizing Barriers

- Physician
 - Lack of time
 - Lack of communication skills
 - Discomfort regarding patient emotions
 - Concerns about "eroding hope"
 - Fear of legal liability
- Patient
 - Lack of awareness of advance planning importance
 - Assumption that physician will initiate discussions
 - Reluctant to discuss death and dying with loved ones

Initiatives

the conversation project



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Ethical Considerations

- Autonomy
- Justice
- Beneficence (to do good)
- Non-maleficence (to do no harm)

Additional Resources

 National Institute on Aging



Conclusion & Recommendations

- Advance planning is a process, not a single event or document
- It's never too early to begin planning
- To practitioners: start the conversation and planning with your families first– that can help

Nancy Cruzan

- A legacy of patient rights surrounding self-determination and personal values
- Fueled the national conversation



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