# Advance Directives in Ohio

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# Learning Objectives

- Understand historical perspective leading up to the development of advance directives in America
- Describe the components of Advance Directives,  (ADs) in Ohio
- Identify potential barriers to completing advance directives as well limitations of the directives
- Explain at least one approach to the conversation with a patient

# Audience Assessment…

- How many of you think advance directives are for the elderly or terminally ill?
- How many of you have had a conversation with your parents, grand-parents, or potentially a spouse about their wishes regarding a Durable Power Of HealthCare Attorney, (DPOCHA) or a living will?
- How many of you have signed your own DPOHCA or living will?

# Historical Perspective

As per Omnibus Budget Reconciliation Act of 1990, Pub.L. No.101-508 & 4206, 4751.

The Patient Self-Determination Act (PSDA of 1990) defines an AD as a written instruction, such as a Living Will, Health Care Proxy, or Durable Power of Attorney over Health Care, to facilitate treatment when the patient is incapacitated.

# The landmark supreme court case that led to the PSDA…

- Cruzan V. Director, Missouri Department of Health, 497 U.S. 261 (1990), was a landmark United States **Supreme Court** case involving a young adult incompetent. The first "right to die" case ever heard by the **Court**, **Cruzan** was argued on December 6, 1989 and decided on June 25, 1990.

# Other Famous "Right to Die" Cases

- Terri Shiavo
- Karen Ann Quinlan
- Brittany Maynard
- Sue Rodriguez
- Noel Conway

Really about the right to die with dignity and to exercise some autonomy by providing adults the opportunity to express their preferences for medical treatment, to educate patients about ADs

# Advance Directives in Ohio Consist of

- Ohio Living Will
- Ohio Durable Power of Attorney for Healthcare
- Ohio DO NOT Resuscitate Form and physician order
- Organ Donation

# Historical Perspective

- 1970's—Living Wills being developed in most states.
- 1989—Federal Supreme Court hears Cruzan Case.
- 1991—'Patient Self Determination Act' passed in US Congress, and into effect; PSDA validated existence of advance directives in each of states.
- 1991—'Durable Power of Attorney for Health Care' legislation in Ohio.
- 1998—'Do Not Resuscitate' legislation passed in Ohio.

# Historical Perspective

- 2003– 'Mental Health declaration' legislation in Ohio.
- 2004—'Living Will' in Ohio updated to include Organ donation decisions.
- 2015, March—DPOAHC and LW updated.
- 2016, August—DPOAHC and LW copyrighted by Ohio Bar Association

# POLST or MOLST- Under discussion in OHIO

- **P**hysician or **M**edical **O**rder for **L**ife **S**ustaining **T**reatment- state dependent
- The National **POLST** Paradigm is an approach to end-of-life planning based on conversations between patients, loved ones, and health care professionals.
- This is NOT an advance directive- it contains medical orders that are actionable immediately based on patient's current condition
- https://www.molst.org

# POLST Adaptation in the US

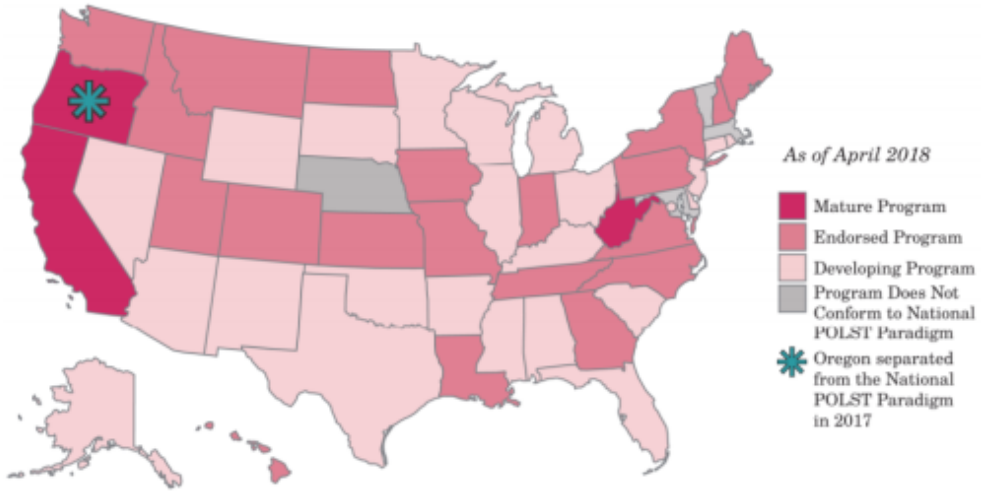
Home | WINGS | Wright | Mail - steven.swedlund@ | Programs in Your State | Microsoft Word - 2018.04

Not secure | polst.org/wp-content/uploads/2018/09/2018.04.11-National-POLST-Program-Designations-Map.pdf

National POLST Paradigm
www.polst.org

## National POLST Program Designations

**As of April 2018**




The National POLST Paradigm set standards for recognizing a program as developing, endorsed, mature, or non-conforming. POLST Program leaders must proactively apply for endorsement or mature status.

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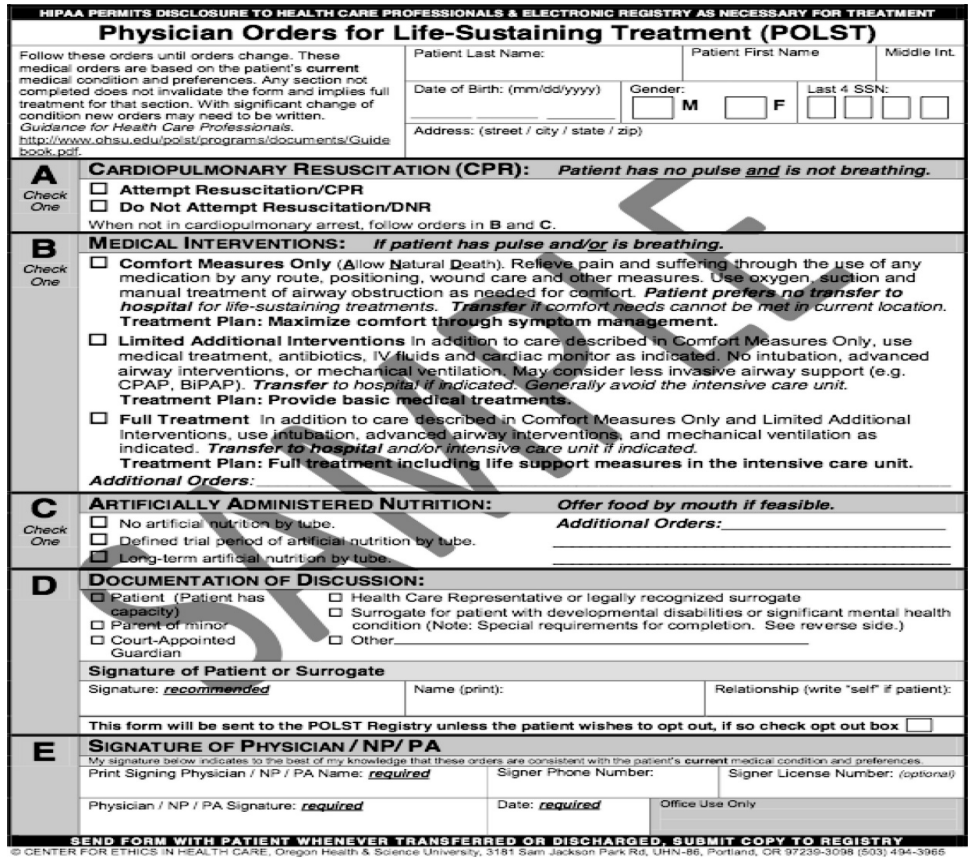
# Example in your Handouts



HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

**Physician Orders for Life-Sustaining Treatment (POLST)**

Follow these orders until orders change. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written. *Guidance for Health Care Professionals.* http://www.ohsu.edu/polst/programs/documents/Guidebook.pdf.

Patient Last Name: | Patient First Name | Middle Int.

Date of Birth: (mm/dd/yyyy) | Gender: ☐ M ☐ F | Last 4 SSN: ☐☐☐☐

Address: (street / city / state / zip)

**A** *Check One* — **CARDIOPULMONARY RESUSCITATION (CPR):** ***Patient has no pulse and is not breathing.***

- ☐ **Attempt Resuscitation/CPR**
- ☐ **Do Not Attempt Resuscitation/DNR**

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

**B** *Check One* — **MEDICAL INTERVENTIONS:** ***If patient has pulse and/or is breathing.***

- ☐ **Comfort Measures Only** (Allow Natural Death). Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments.* ***Transfer*** *if comfort needs cannot be met in current location.* **Treatment Plan: Maximize comfort through symptom management.**
- ☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.* **Treatment Plan: Provide basic medical treatments.**
- ☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.* **Treatment Plan: Full treatment including life support measures in the intensive care unit.**

***Additional Orders:*** _____

**C** *Check One* — **ARTIFICIALLY ADMINISTERED NUTRITION:** ***Offer food by mouth if feasible.***

- ☐ No artificial nutrition by tube.
- ☐ Defined trial period of artificial nutrition by tube.
- ☐ Long-term artificial nutrition by tube.

***Additional Orders:*** _____

**D** — **DOCUMENTATION OF DISCUSSION:**

- ☐ Patient (Patient has capacity)
- ☐ Parent of minor
- ☐ Court-Appointed Guardian
- ☐ Health Care Representative or legally recognized surrogate
- ☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)
- ☐ Other_____

**Signature of Patient or Surrogate**

Signature: ***recommended*** | Name (print): | Relationship (write "self" if patient):

**This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box** ☐

**E** — **SIGNATURE OF PHYSICIAN / NP/ PA**

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

Print Signing Physician / NP / PA Name: ***required*** | Signer Phone Number: | Signer License Number: *(optional)*

Physician / NP / PA Signature: ***required*** | Date: ***required*** | Office Use Only

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. SUBMIT COPY TO REGISTRY**

# Ohio Living Will

- Takes effect in two situations:
  - Permanently unconscious state
  - Terminal state

  * Trumps DPOHCA*
- Consider Uslivingwillregistry.com

# DPOHCA

- Specifies who you want to represent your wishes about medical treatment when you cannot represent yourself. This person speaks for you - he/she does not decide for you.
- Goes into effect during periods of incapacity (Like post surgery or after  an accident.)
- Should be discussed with and agreed to by all parties in advance
- Copies of this form should be given to PC, family, DPOHCA, and possible close friends.

# DNR Forms

Is an order signed by **doctor (or advanced care practitioner. PA or NP**) which specifies patient's wishes about resuscitation at end of life (2 levels):

DNRCC- DO not Resuscitate/ Institute Comfort care at the present time

DNRCC-A: DO not resuscitate / Institute Comfort Care at time of  Arrest

# DNR-CC

- A person receives any care that eases pain and suffering, but no resuscitative measures to save or sustain life.
  - This protocol is activated immediately when a valid DNR order is issued or when a living will requesting no CPR becomes effective.

# DNR-CC

**WILL:**

- Suction the airway
- Administer oxygen
- Provide pain medications
- Position for comfort
- Splint or immobilize
- Control bleeding
- Provide emotional support; contact other health care providers

**WILL NOT:**

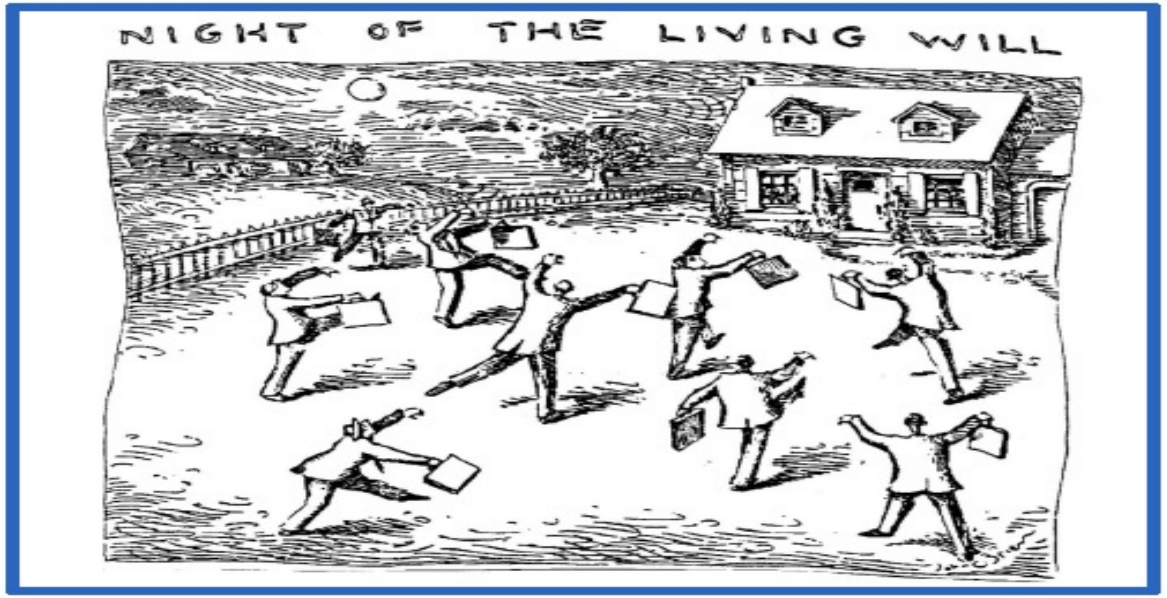
- Start chest compressions
- Insert an artificial airway
- Administer resuscitation drugs
- Defibrillate or cardiovert
- Administer respiratory assistance

# DNR-CC Arrest

- A person receives standard medical care until the time he or she experiences a cardiac or respiratory arrest.
  - Standard medical care may include cardiac monitoring or intubation prior to the occurrence of cardiac or respiratory arrest.
  - This protocol is activated when the patient has a cardiac or respiratory arrest.

# The Advance Directives Discussion…. It can surprise the patient

## Advance Directives




UCSF San Francisco VA Medical Center
Division of Geriatrics

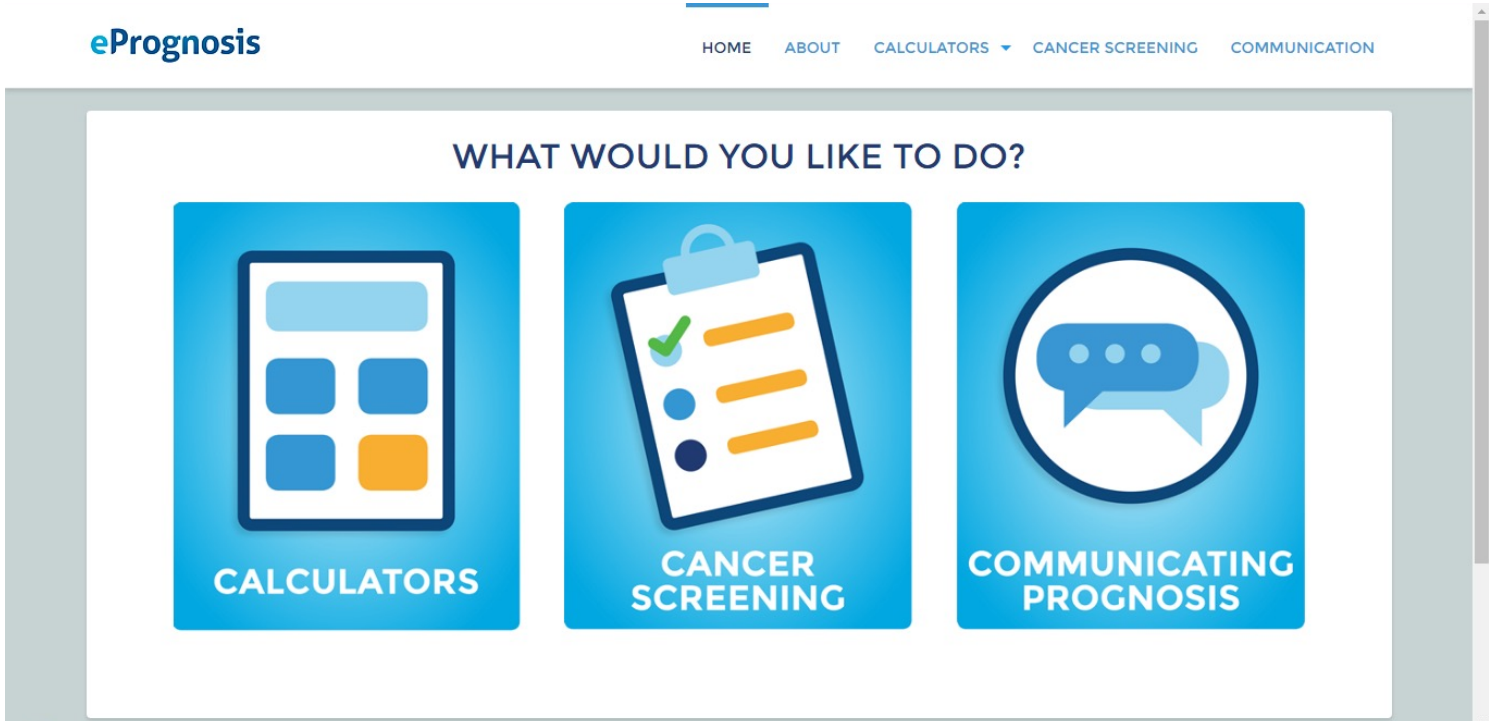
# Ways to approach the topic

- Think about your patient in advance. (Does your patient have a life-limiting illness?)
- Ask " Is it ok to talk about the future of your condition?"
- Ask about patient's self-assessment: "Please tell me what you know about your condition?"
- Let the patient know that " We don't have to make decisions today"

# Things to include in your discussion

- Information preferences
- Prognosis- ask how much they want to know*
- Goals
- Fears or worries
- Function
- Trade offs
- Family
- Summarize
- Next steps

# Consider using Eprognosis



# Next Steps

- Affirm your commitment.
- Make recommendations but empower pt. with  autonomy
- Document your conversation in the chart for others to see
- Provide patient with education for use with their family
- Understand and share that this is rarely a one and done discussion

# For Use with Family

# Barriers to completing ADs

- Advance Care Planning ACP  fits into continuity care, but patient care is often intermittent
- Timing and schedule may not match for discussing ADs
- Literacy levels of ACP forms and patients may not match
- Knowledge and education of patients and physicians, PAs, CNSs, NPs.
- Comfort level of patients and physicians, PAs, CNSs, NPs.
- Patients often do not express values to DPOAHCs.

# Things to Remember…

- Advance Care Planning (ACP) is set up to match a patient's goals with his/her medical treatment.
- There is no 'one best practice' for health care providers to follow, when addressing ACP.
- Tools for engaging in ACP conversations are being developed.

- Living Wills, DPOAHC are examples of advance directives.
- DNRCC and DNRCCA are specific orders to facilitate advance care planning.
- ACP is a process which involves ‘shared decision making’ and ‘enhanced autonomy.’

# Case Study

- A 67 y.o. male has been on mechanical ventilation for 12 days, since he was admitted to hospital for pneumonia and an exacerbation of severe COPD
  - PMH includes CAD, CHF-PEF, pulmonary HTN.
  - Prior to admit, he was independent in all ADLs and IADLs

# Case Study continued

- On admit, he was judged capable to make medical decisions.  With his consent, he was treated with antibiotics and corticosteroids, and was intubated and placed on ventilator
  - He remains on ventilator due to excess secretions, weakness, poor mental status, and persistently high O2 requirement.
  - His prognosis is poor.

# Case Study Continued

- Patient has been close to his niece and she is designated as his DPOAHC, and he has a living will (L.W.)
  - Niece has been involved daily, in his care
  - His L.W. specifies that he would want life prolonging measures withheld or withdrawn with comfort care only, if his life expectancy were <6 months, or if he were permanently unconscious

# Case Study Continued

- The care team recommends DNRCC only, with extubation, and comfort care
  - The niece rejects this, and insists on continuing life prolonging measures, and tracheotomy and PEG tube placement.
- What would you recommend next?

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