Advance Directives

THE FACTS

THE PROCESS

What are Advance Directives

- Advance Directives are an expression of a person's preferences for medical care that are based on a person's values and beliefs
- Advance Directives come into play when that person is unable to, or chooses not to speck for themselves
- Advance directives also include identification of a surrogate or proxy, some one who will represent the person's preferences in decision making

Examples of Advance Directives

- Health Care Proxy (MA)
- Living Will (NH)
- Durable Power of Attorney for Healthcare (DPOHA) (NH)

Why Advance Directives

- Ideally, advance directives reflect a process of conversation that the person had and decisions made while the person had decision making capacity
- Advance Directives at their best reflect discussions among the person's family, surrogate and health care provider about the person's preferences health care in the context of serious illness
- The recognition of the terminal nature or phase of illness is an ideal impetus for preferences and identification of a surrogate
- Coordination of these efforts is especially important with person's living with advanced cancer, dementia, HIV/AIDS, end-stage renal disease, chronic heart failure and neurodegenerative disease

Advance Directives

- Advance Directives are legally valid throughout the US
- While you do not need a lawyer to fill out an advance directive, your advance directive becomes legally valid as soon as it is signed before the required number of witnesses
- The laws governing advance directives vary from state to state, so it is important to complete the directive in compliance with state law
- EMTs cannot honor living wills or medical powers of attorney.
- Once emergency personnel have been called they must do what is necessary to stabilize a person for transfer to hospital, both from accident sites and from a home or facility.
- After a physician fully evaluates the person's condition, can the advance directives be implemented

Massachusetts Health Care Proxy

- The Health Care Proxy protects the person's right to refuse medical treatment not wanted, or to request treatment that is wanted, by appointing an agent to act on behalf in the event the ability to make decisions is lost
- Massachusetts does not have a statute governing the use of Living Wills, therefore Living Wills are not recognized
- The proxy form includes an optional organ donation form. If there are no instructions regarding organ donation, the family or proxy has decision making authority
- The Massachusetts Health Care Proxy goes into effect then the physician determines that the person is no longer able to communicate health care decisions

Massachusetts Health Care Proxy

- The health care proxy form does not expressly address mental illness
- If advance directives are to be made involving mental illness, legal durable power of attorney should be considered
- The agent should be someone that is trusted to make serious decisions
- The agent should clearly understand the person's wishes and be willing to accept the responsibility of making medical decisions for the person
- The law requires that the person sign the document in the presence of two adult witnesses, who must also sign the document to show that they believes the person is at least 18 years of age, of sound mind and under no constraint or undue influence

Massachusetts Health Care Proxy

- The person appointed as the agent cannot serve as a witness
- Massachusetts Health Care Proxies does not need to be notarized
- The Health Care Proxy can be revoked at any time by:
- Notifying your agent or doctor orally or in writing
- Taking any action, such as tearing up or destroying the document that indicates specific intent to revoke the proxy
- Executing another Health Care Proxy
- If you have appointed your spouse as your agent, and your marriage ends, the Health Care Proxy is automatically revoked

NH Durable Power of Attorney for Health Care

- Similar in intent as MA Health Care Proxy
- Document delegating health care decisions to agent, includes consent, refusal to consent or withdrawal of consent to any care, treatment, admission to health care facility, any service or procedure to maintain , diagnoses or treat an individual's physical or mental condition. Artificial nutrition and hydration may not be withdrawn unless clear expression of such power in document.
- Does not include power to consent to voluntary admission to state institution, voluntary sterilization or consent to withholding life-sustaining treatment for pregnant patient unless treatment will not permit continuing development and live birth of unborn child

NH Durable Power of Attorney for Health Care

- Part I is the NH Power of Attorney for Health Care- allows for naming of an adult, called the agent, to make decisions about health care, including decisions about life-sustaining treatments, when the person can no longer speak for themselves
- Also allows for specific instructions for health care and other advance planning decisions
- Part II is the New Hampshire Declaration which is the state's living will. The declaration is limited to a statement that the person wants life-sustaining treatment withheld or withdrawn if near death of permanently unconscious
- Can leave Part II blank and convey specific wishes in Part I only

NH Durable Power of Attorney for Health Care

- Document must be signed in the presence of two witnesses. Neither of the witnesses can be:
- The agent, the spouse, any heir or person entitled to any part of the estate or the attending physician , ARNP, or any person acting under the direction of the attending physician or ARNP
- The health or residential care provider or an employee of the health or residential care provider
- The revocation elements are the same, but also includes "Person who is directly interested or related to person may file an action to revoke durable power of attorney on grounds that the person was not of sound mind or under duress, fraud or undue influence

Medical Orders for Life Sustaining Treatment- MOLST (MA)

- MOLST Mission- To facilitate and promote use of the MOLST process and for as the standard way to document, communicate and honor the life-sustaining treatment preferences of patients with advanced illness in all Massachusetts health care settings
- MOLST is a medical order form that relays instructions between health professionals about a patient's care. MOLST is based on an individual's right to accept or refuse medical treatments that might extend life.
- MOLST is not for everyone. In Massachusetts patients with a serious advanced illness at any age may discuss completing a MOLST form with their clinician. The patient's decision to use the MOLST must be voluntary

Medical Orders for Life Sustaining Treatment- MOLST (MA)

- The process before completing a MOLST requires discussions between the signing clinician (Physician, ARNP, or PA) the patient, and family members/trusted advisors about:
- The patient's current medical condition
- What could happen next
- The patient's values and goals for care
- Possible risks and benefits of treatments that may be offered
- Discuss the burdens and benefits of CPR, ventilation, hospitalization and other life-sustaining treatments

Medical Orders for Life Sustaining Treatment- MOLST (MA)

- The patient signs the MOLST as well and stays with the patient and is to be honored by health professionals in any clinical care situation
- The MOLST form is not an advance directive because it is a medical document that contains actionable medical orders that are effective immediately based on a patient's current medical condition
- Advance directives such as health care proxies and living wills are legal documents that are effective only after the patient has lost capacity
- A MOLST form is a medical document signed by the clinician and the patient, and is effective as soon as it is signed, regardless of the person's capacity to make decisions

MOLST, Comfort Care (CC)/DNR Orders

- The MA CC/DNR form remains valid. The CC/DNR form can still be used to document that a valid DNR order exists for a patient, and it will be honored by EMTs in outpatient settings
- Because the MOLST (an actual medical order form) can be filled out to indicate "DNR" if that is patient's decision, the MOLST form can be used instead of the CC/DNR form
- In some situations, patients may have both MA/CC and MOLST forms. If both forms are present, in the event of cardiac or respiratory arrest, the most recent orders should be followed
- In events other than cardiac or respiratory arrest, the MOLST orders should be followed

NH Provider Orders for Life Sustaining Treatment (POLST)

- The POLST has the same intent and purpose of the MOLST
- It can be signed by a physician or NP, and of course signed by the patient
- Key sections of POLST
- Full medical treatment- for patients who wan full treatment including use of a breathing machine and other treatments usually provided in an intensive care unit
- Limited Medical Intervention- for patients who to go to a hospital for basic medical treatments such as antibiotics for pneumonia, oxygen, IV fluids or cardiac monitoring. These patients generally want to avoid the intensive care unit

NH Provider Orders for Life Sustaining Treatment (POLST

- Comfort Measures Only- for patients who want the focus of their care on maximizing their comfort through symptom management and prefer not to go to the hospital
- Recent NH law revisions allow the POLST to be considered as an active DNR order is that is what the patient as indicated
- No additional DNR form is required

MOLST/POLST vs. Health Care Proxy Form

	MOLST	Health Care Proxy
Form Type	Medical document	Legal Document
Form Users	Patients of any age with advanced illness	All adults (18 +) healthy or sick
Form contains	Current medical orders about life sustaining treatment	Name of person's appointed health care agent for future shared decision making
Goes into effect	Immediately upon signing	Only if person is declared to lack capacity to make own health care decisions
Form Signed	The patient and clinician (or health care agent if patient lacks capacity)	The person and two witnesses of

Hospice Role

- Identify if patients do have a n advance directive in place
- Is it current and reflect current wishes and status?
- If none in place, encourage conversation about the purpose and importance of an advance directive
- An advance directive and a MOLST/POLST complement each other, patients may be confused about the two documents, leading some individuals to consider only one while ignoring the benefit of the other
- Clinical experience and research demonstrate that advance care directives are sufficient to ensure that care goals of patients with serious advanced illness will be honored unless a MOLST/POLST form is completed

Hospice Role

- All members of the IDT are responsible for discussing the benefits of advance directives and MOLST/POLST form
- Our Social Workers are experts in initiating and continuing this discussion
- All are responsible for education and support to the family regarding these important decisions

It's About How You Live

- Live-National Campaign encouraging persons to make informed decisions about end of life services
- Campaign encourages people to"
- **L**earn about options for end of life services and care
- **I**mplement plans to ensure wishes are honored
- **V**oice decisions to family, friends and health care providers
- **E**ngage in community efforts to improve end of life care