HONORING CHOICES
ADVANCE CARE PLANNING
IN INDIANA
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www.dhblaw.com
## UNDERSTANDING ADVANCE DIRECTIVES

<table>
<thead>
<tr>
<th>Advance Directives</th>
<th>Hospital Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Health Care Representative</td>
<td>▪ AND: Allow Natural Death</td>
</tr>
<tr>
<td>▪ Health Care Power of Attorney</td>
<td>▪ DNR: Do Not Resuscitate</td>
</tr>
<tr>
<td>▪ Living Will</td>
<td>▪ No-Code/Physician</td>
</tr>
<tr>
<td>▪ Life Prolonging Procedure Directive</td>
<td>▪ When death is imminent</td>
</tr>
<tr>
<td>▪ Out of Hospital DNR</td>
<td></td>
</tr>
<tr>
<td>▪ Psychiatric Advance Directive</td>
<td></td>
</tr>
<tr>
<td>▪ Organ and Tissue Donation</td>
<td></td>
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<tr>
<td>▪ Funeral Directives</td>
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### P.O.S.T.

Physician’s Order for Scope of Treatment

## WHAT ARE THE PRIMARY DIFFERENCES BETWEEN ADVANCE DIRECTIVES AND POST?

<table>
<thead>
<tr>
<th>Advance Directives</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ For anyone 18 and older</td>
<td>▪ For persons with serious illness – at any age</td>
</tr>
<tr>
<td>▪ Provides instructions for future treatment</td>
<td>▪ Provides medical orders for current treatment</td>
</tr>
<tr>
<td>▪ Appoints a Health Care Representative</td>
<td>▪ Guides actions by Emergency Medical Personnel when made available</td>
</tr>
<tr>
<td>▪ Does not guide Emergency Personnel</td>
<td>▪ Guides inpatient treatment decisions when made available</td>
</tr>
<tr>
<td>▪ Guides inpatient treatment decisions when made available</td>
<td></td>
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</tbody>
</table>
PURPOSE OF POST

- To provide a mechanism to communicate seriously ill patients’ preferences for end-of-life treatment across care settings
- To improve implementation of advance care planning by providing more specific instructions for seriously ill patients

PRACTICE POINT

- Should we draft health care forms addressing how the POST form should be completed if you are determined to be a qualified person?
- At the very least clients should be having the conversation with the Health Care Representative/POA on what those wishes are, should they become a qualified person and are unable to make the decision themselves.
- Who is a “qualified person”?  

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WHO CAN HAVE A POST?

- Qualified Persons
  - An advanced chronic progressive illness;
  - An advanced chronic progressive frailty;
  - Terminal condition; or
  - Unlikely to benefit from CPR.

Would the physician be surprised if the patient died within the next year?

PROPOSED POST CHANGES

- Do we need to complete the entire form?
- Advance Practice Nurse can sign
- When can HCPOA cancel POST
  - Good Faith?
- Out of State POLST FORM
HAVING THE CONVERSATION

- **Changing focus: What does it mean to you to live well?**
- **Other suggestions:**
  - When you think about the last phase of your life, what’s most important to you? How would you like this phase to be?
  - Would you prefer to be actively involved in decisions about your care? Or would you rather have your doctors do what they think is best?
  - Are there circumstances that you would consider worse than death?
  - Where do you want (or not want) to receive care?
  - What kinds of aggressive treatment would you want (or not want)?
  - When would it be okay to shift from a focus on curative care to a focus on comfort care alone?

HEALTH CARE BY COMMITTEE

- Indiana law makes your parents, your adult siblings, your spouse and your adult children, all committee members, who vote on your health care if you are incapacitated.

- This is not a good plan!
- Gramps Gets a Vote!
HEALTH CARE BY COMMITTEE CHANGED TO MAJORITY RULES.

- Mom has no advance directive.
- She has two sons, a Republican and a Democrat.
- Gridlock – Ethics Committee Consult needed

“AN ADULT OF CARE AND CONCERN”

- Will your UBER Driver make health care decisions for you?
- SB 193 introduced last year would create priorities among the classes and add the concept of “an adult of care and concern”.
The new (proposed) priority order for Hoosiers too lazy to sign an Advanced Directive

- Spouse
- Adult Child
- Parent
- Grandparent
- Adult Grandchild
- Next of Kin
- Friend
  (Majority of any class)

Who cannot consent?
- A spouse who is legally separated
- An individual under protective order
- Pending criminal charges involving the patient
- Anyone you specifically name in HCPOA!!!
OUTLIVING YOUR LIVING WILL

- A Living Will only become effective when a doctor certifies in writing:
  - The patient has an incurable injury, disease, or illness;
  - The patient’s death will occur within a short time; and
  - The use of life prolonging procedures would serve only to artificially prolong the dying process.
- Doctors do not do this.
- Change our living will to name a surrogate

THE CONVERSATION

- Consider making a video documenting the conversation about end of life healthcare decisions for the benefit of the child than lives in California.
ADVANCE CARE PLANNING...

- is a process
- is not a “one size fits all” discussion
- must be individualized to patient readiness and stage of health
- requires advance care planning facilitation skills to address stage of planning
- benefits from a team approach

Stages of Advance Care Planning Over the Lifetime of Adults

<table>
<thead>
<tr>
<th>First Steps</th>
<th>Next Steps</th>
<th>Last Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create POAHC and consider when a serious neurological injury would change goals of treatment</td>
<td>Determine what goals of treatment should be followed if complications result in “bad” outcomes</td>
<td>Establish a specific plan of care expressed in medical orders using the POST paradigm</td>
</tr>
</tbody>
</table>

Healthy adults who have not planned | Adults with progressive, life-limiting illness, suffering frequent complications | Adults whom it would not be a surprise if they died in the next 12 months |
MEDICAL CAPACITY

- Ability to make and communicate decisions
- Understand risk/reward of treatment
- Make an informed choice

THE CHALLENGE

- We have progressed from the living will, to the health care power of attorney, to the POST form. We have to change our culture and our society with a goal of 90% of eligible Hoosiers having an advance directive in their medical record at the time of death.
ADDITIONAL RESOURCES

- Consumer’s Tool Kit for Health Care Advance Planning
  http://ambar.org/agingtoolkit.
- The Go Wish Game
  www.codaalliance.org.
- The Indiana POST program
  www.indianapost.org

WHAT IS A LAWYER’S ROLE IN RESPECTING CHOICES?

- Prepare the document
- Start the conversation
- Educate the family
- Arrange for the document to get into the electronic medical record
EDUCATE YOUR COMMUNITY

- Volunteer to speak at Nursing Homes – many have yet to see their first POST form
- Audit a Respecting Choices training program
- Find out who has been trained under the Respecting Choices Program so you can refer clients

Available at: https://agingihs.org/uploads/page/Honoring%20Choices%20Indiana%20Community%20Partner%20Map.pdf

and at the end of the materials
THE CHALLENGE

- We now have an Honoring Choices Indiana program.
  - Visit: www.honoringchoices.org

THE CHALLENGE

- The Indiana Bar Association needs to partner with Regional/State Medical Societies to implement a model program for end of life planning.
Indiana has enacted the Caregiver Advise, Record, and Enable (CARE) Act. The CARE Act is designed to help the family caregiver help a family member post-hospitalization. The law provides:

- You or your health care representative can name a friend, caregiver, or other family member as a Lay Caregiver.
- Your health care representative can be your Lay Caregiver.
- The hospital must notify the Lay Caregiver before you are discharged from the hospital.

The hospital employee will provide an explanation and instructions for your post-hospital care. This can include medication management, wound care, transferring from a wheelchair, and other tasks the Lay Caregiver will perform at home that the hospital recommends.

- The hospital is required to develop and communicate to your Lay Caregiver a home care plan you need upon discharge from the hospital.
- The hospital may give live or recorded demonstrations to properly prepare the Lay Caregiver for the aftercare described in your home care plan.
Our Community-based Care Transitions Program (CCTP) Experience

Seizing the Opportunity

CCTP Coalition – High Performers Got Results; National Learning Lab

Number of Individuals Served from beginning of CCTP to Date: 254,225

Net Medicare Cost Savings to Date: $86,870,179.10

Please note: this information reflects data submitted from local coalition studies (September, 2015)
Our CCTP Results

<table>
<thead>
<tr>
<th>Patients served:</th>
<th>15,730</th>
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<tbody>
<tr>
<td>Baseline readmission:</td>
<td>17.7%</td>
</tr>
<tr>
<td>CCTP readmission:</td>
<td>10.8%</td>
</tr>
<tr>
<td>Net Medicare Savings:</td>
<td>$5.5 Million</td>
</tr>
</tbody>
</table>

Person Centered Care

- What is person-centered care?
  - It respects the individual
  - It addresses the individual’s preferences and needs
  - It places the individual at the center of
    - **WHAT** care is provided
    - by **WHOM**
    - and **WHEN**
  - It begins with the individual’s goal(s)

**Portfolio:**
- Screenings & Assessment
- Person & family centered planning
- Care transition support
- Care coordination
- Chronic disease management
- Behavioral health support
- Caregiver support
- Long-term service support
- Advance Care Planning

**QUESTIONS?**