Vermont Medical Society
Wednesday Webinar Series

Date: November, 15, 2017
Title of Talk: End of Life Planning—Advanced Care Planning, DNR/COLST, Vermont’s Medical Aid in Dying Law

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Webinar materials archived at: http://www.vtmd.org/vms-announces-free-webinar-series-schedule-201718
CME DISCLAIMER

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VMS Wednesday Webinar Series
End of Life Planning - Advanced Care Planning, DNR/COLST, Vermont’s Medical Aid in Dying Law

Speakers:
Cindy Bruzzese, MPA, MSB, Vermont Ethics Network  
David Englander, Esq., Vermont Department of Health

Planning Committee Members:
Jessa Barnard, ESQ, Wendy Davis, M.D., FAAP & Stephanie Winters

Purpose Statement/Goal of This Activity:
Increase knowledge of End of Life Planning, DNR/COLST, and Vermont Medical Aid in Dying Law

Disclosures:
Is there anything to Disclose? Yes No

Did this activity receive any commercial support? Yes No

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Objectives

• Review best practice for advance care planning & communication strategies.

• Review available tools for documenting patient preferences.

• Overview of surrogate decision-making & new legal framework for surrogate consent for DNR/COLST orders.
Advance Care Planning - Terminology

• **Advance Care Planning** = Planning in Advance of Serious Illness
  - Appointing a Health Care Agent
  - Completion of Advance Directives with Discussions about Preferences

• **Serious Illness Conversation** = Planning in the context of progression of serious illness
  - Diagnosis of Serious or Chronic Illness(es)
  - Progression of Serious or Chronic Illness(es)

• **Goals of Care Conversation** = Decision making in the context of clinical progression, decline, crisis, poor prognosis

Max Vergo, Meredith MacMartin, Amelia Cullinan. DHMC & Geisel School of Medicine Palliative Care Team (2017)
ACP Continuum

Name a Health Care Agent

Advance Directive w/Preferences

Conversations about Goals & Priorities

Discuss DNR/COLST

EOL Decision Making

Shigeko Izumi, PhD, RN, FPCN1 and Erik K. Fromme, MD, MCR, FPCN. Journal of Palliative Medicine. Vol 20; No.7, 2017
VEN – Stepwise Approach

1. Appoint a Health Care Agent
2. Document Health Care Goals, Preferences & Priorities
3. Consider DNR/COLST Orders
Advance Directives (Steps 1 & 2)

Preference-based documents completed by capacitated patients to guide future medical decisions if the patient loses capacity, becomes terminally ill or is permanently unconscious.

Values based documents that are typically nuanced requiring discussion, context and interpretation.

- FORMS: Appointment of a Health Care Agent Form Short & Long Form AD
DNR/COLST Orders (Step 3)

Medical orders completed by clinicians, require informed consent, binding orders for current treatment decisions.

NOTE: Consent can be provided by others if patient lacks capacity

FORM: Vermont DNR/COLST Order (out-of-hospital)
Facility specific documentation (in-patient)
Shared Decision-Making for DNR/COLST

Patient Values, Goals & Priorities

Medically Appropriate Goal-Directed Interventions

Recommendation by Clinician
Who should clinicians talk to about DNR/COLST orders?

• The “Surprise” Question

• Those with serious, advanced or life-limiting conditions.

• Those who reside in long-term care facilities.

• Those who want to limit or avoid life-prolonging interventions—regardless of the clinical context.
Serious Illness Conversation Guide

- Framework for best communication practices

- Tool to make it easier for clinicians to have conversations with their seriously ill patients about prognosis, values, goals and priorities.

- Developed after an extensive review of literature, a national expert panel, and iterative testing with clinicians, patients and families.

<table>
<thead>
<tr>
<th>Conversation Flow</th>
<th>Patient-Tested Language</th>
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| 1. Set up the conversation  
Introduce the idea and benefits  
Ask permission | “I’m hoping we can talk about where things are with your illness and where they might be going — is this okay?” |
| 2. Assess illness understanding and information preferences | “What is your understanding now of where you are with your illness?”  
“How much information about what is likely to be ahead with your illness would you like from me?” |
| 3. Shore prognosis  
Tailor information to patient preference  
Allow silence, explore emotion | Prognosis: “I’m worried that time may be short.”  
or “This may be as strong as you feel.” |
| 4. Explore key topics  
Goals  
Fears and worries  
Sources of strength  
Critical abilities  
Tradeoffs  
Family | “What are your most important goals if your health situation worsens?”  
“What are your biggest fears and worries about the future with your health?”  
“What gives you strength as you think about the future with your illness?”  
“What abilities are so critical to your life that you can’t imagine living without them?”  
“If you become sicker, how much are you willing to go through for the possibility of gaining more time?”  
“How much does your family know about your priorities and wishes?” |
| 5. Close the conversation  
Summarize what you’ve heard  
Make a recommendation  
Affirm your commitment to the patient | “It sounds like _______ is very important to you.”  
“Given your goals and priorities and what we know about your illness at this stage, I recommend…”  
“We’re in this together.” |
| 6. Document your conversation |  |
Legal Standard for Surrogate Decision Making

1. **SUBSTITUTED JUDGMENT** – based on knowledge of what the patient would choose (advance directive, conversations, goals, values)

2. **BEST INTERESTS** – based on what “most” people would choose, in a similar situation with similar resources at hand
Surrogate Consent for DNR/COLST

CURRENTLY:

• If a patient lacks capacity, a health care agent, medical guardian (with appropriate authorization) or other individual can provide consent.

• Term “other individual” is undefined.

• Standard for how this person will make the decision is not addressed.

18 V.S.A. § 9708
Overview: Effective January 2018

Section 9731 of Vermont AD Statute:

- Outlines a process for determining who can give informed consent for a DNR/COLST order when a patient lacks capacity, has not appointed a health care agent, and does not have a guardian authorized to make medical decisions.

- Consensus based model – no hierarchy

- Prioritizes substituted judgement over best interest as the standard for decision-making across all care settings.

- Only applies to decisions to either consent or withhold consent for DNR/COLST orders.

18 V.S.A § 9731
Definitions

- **Surrogate:** an *interested individual* who provides or withholds informed consent for a DNR/COLST order.

- **Interested Individual:**
  - The principal’s or patient’s spouse, adult child, parent, adult sibling, adult grandchild or clergy person; or
  - Any adult who has exhibited special care and concern for the principal or patient and who is personally familiar with the principal’s or patient’s values.


Note: Interested Individuals cannot be the patient’s health care provider; or the owner, operator, employee of a res. care facility or correctional facility where patient resides — unless related to the patient.
Identification of a Surrogate

• Oral Designation Permitted. Clinician shall document in the medical record at the time of designation. §9731(c)(1)

• If no oral designation (or if that person is unwilling or unable to serve) the clinician shall:
  • Make a reasonable attempt to notify all reasonably available interested individuals of the need for a decision regarding DNR/COLST order

• Eligible surrogates: Must be an interested individual who:
  • Is willing to consent/withhold consent in accordance with patient’s wishes (if known); and
  • Is willing & available to consult with the patient’s clinician

• Only one surrogate can act at a time

18 V.S.A § 9731
Consensus Model – No Hierarchy

Can rely on the decision of the surrogate as long as it is documented that one of the following applies:

1. **All interested individuals agree on the decision** surrounding the DNR/COLST order. One surrogate will be identified, as well as an alternate if available, and that person’s name will be identified on the DNR/COLST form and in the patient’s medical record.

2. **All interested individuals agree on the person** who should be identified as the surrogate to make the decision surrounding the DNR/COLST order. That person shall be identified on the form and in the patient’s medical record.

18 V.S.A § 9731
Involvement of the Court

If interested individuals are unable to agree on the designation of a surrogate, an interested person (per 14 V.S.A § 3061) may file a petition for guardianship in the Probate Division of the Superior Court.
Thank You

To download Forms:
www.vtethicsnetwork.org

Contact Information:
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cbruzzese@vtethicsnetwork.org
PATIENT CHOICE AND CONTROL AT END OF LIFE
VERMONT MEDICAL SOCIETY
NOVEMBER 15, 2-17

David Englander, Senior Policy and Legal Advisor

- Allows Vermont physicians to prescribe a dose that is intended to hasten death
  - Patient must incurable and irreversible disease which would, within reasonable medical judgment, result in death within six months. Death must be anticipated within six months.
  - Patient must be capable
- Provides liability protections for doctors and other health care providers and others
- Set forth a step-wise process to, in effect, create a standard of care
  - All participation by all parties must be voluntary
- Requires participating physicians to file documents with the Department of Health
- The Department maintains forms for reporting
  - While reporting is mandatory the use of the VDH forms is not
Patient Request for Medication Form
## Consulting Physician Reporting Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>A</strong></td>
<td>Patient Information</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Report Date</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Consulting Physician Information</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>Description of Injury/Loss</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>Consultant's Observations</td>
</tr>
</tbody>
</table>

- **A**: Name and Date of Injury/Loss
- **B**: Date of Report
- **C**: Name and Title of Consulting Physician
- **D**: Description of Injury/Loss
- **E**: Consultant's Observations

The form includes space for the reported injury/loss details and the consultant's observations, ensuring comprehensive documentation for reporting purposes.
Vermont

Patient Choice at End of Life — Physician Follow-up

Date: __________/_______/_______

Physician

In accordance with Patient Choice at End of Life regulations, physicians who are prescribing for a patient, during the phase of advance care planning, are required to complete this form within 30 calendar days of the patient's death. If this form is not completed within that 30-day period, it becomes the physician's responsibility to ensure that the form is completed within 30 calendar days from the time of the patient's death.

For the Department of Health to accept this form, it must be signed by the prescribing physician. The title of this position is the person at the patient's place of death.

The form should be returned to the address below. All information is legally protected, completed Electronically or printed. (Notify of any changes or updates)

Date: __________/_______/_______

Physician Name: ___________________________

Name of the Physician: ___________________________

The patient is free to choose the level of care at the hospital or facility where the patient is residing. This includes any level of care, from inpatient care to home care, or from a hospital to a skilled nursing facility. If changes are made to the patient's care, please check the box indicating that.

1. Patient Choice (Inpatient care)
2. Patient Choice (Outpatient care)
3. Patient Choice (Home care)
4. Patient Choice (Other)

Date: __________/_______/_______

Physician Signature: ___________________________

Date: __________/_______/_______
Act 27 (2015)

- **Key Points**
  - Eliminated the provisions of Act 39 (2014) that would sunset the step-wise process set forth under the original Act (18 V.S.A. § 5283) and replace it with broad liability protection
  - Required the Department of Health to adopt a rule in order to collect information and report to the legislature information consistent with HIPAA
Resources
