# VCU PALLIATIVE CARE ECHO

## PERSON-CENTERED ADVANCE CARE PLANNING AND PALLIATIVE CARE

Honoring Choices® VIRGINIA

UNIVERSITY of VIRGINIA | Institute of Law, Psychiatry, and Public Policy

1

# PRESENTERS

**Eleanor Jones, MEd**

Director, Honoring Choices Virginia

Respecting Choices® First Steps ACP Facilitator, Instructor, and National Organizational Faculty

Qualified Advance Directive Facilitator and Instructor, Commonwealth of Virginia

**Heather Zelle, JD, PhD,**

Associate Professor of Research, Department of Public Health Sciences

Associate Director, Mental Health Policy Research, Institute of Law, Psychiatry, & Public Policy

University of Virginia

2

# OBJECTIVES

01 Identify and describe the elements of an advance directive for health care that addresses mental health

02 Explain the interaction of capacity, mental health, and advance care planning in treatment decision-making

03 Describe barriers to effective communication regarding patient goals of care and mental health

04 Illustrate the importance of advance care planning and patient-specific considerations including mental and physical health and personal beliefs

3

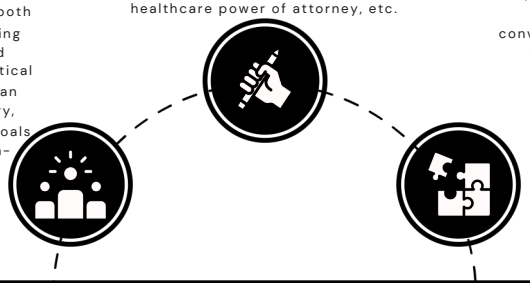
# START WITH THE PERSON, NOT THE FORM

**Conversation Before Forms**

Advance Care Planning (ACP) and Advance Directives (AD)are both important but having person-centered conversations is critical to learning about an individual's history, fears, beliefs, and goals (medical and non-medical)

**Many Forms, Same Goal**

The conversation goal is the same, regardless of the form you use or the motive for having it - chronic illness, end-of-life, mental health, healthcare power of attorney, etc.



**Person-Centered Advance Directives**

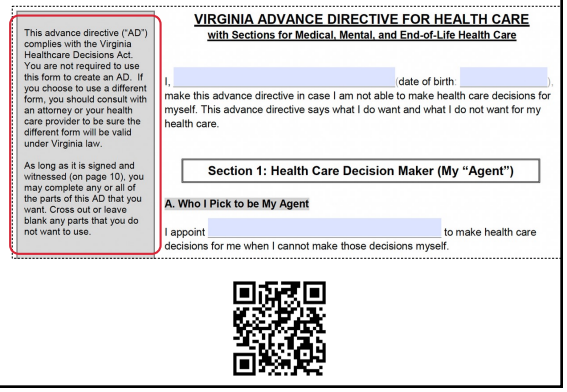
Whichever form you use, be sure to capture the full ACP conversation and tailor the form to the individual.

4

# COMPREHENSIVE ADVANCE DIRECTIVES

The ***Virginia Advance Directive For Healthcare with Sections for Medical, Mental, and End-Of-Life Health Care*** is a comprehensive option based on the Code of Virginia § 54.1-2981

- Includes:
  - Mental health hospitalization, with activation option
  - Protest Provision
  - Healthcare Preferences and Instructions
  - Provider Information Sharing
  - Emergency Contacts
  - Medications
    - preferences and refusals
  - Mental Health Crisis Intervention
  - Care Details
    - visitation instructions
    - Electroconvulsive Therapy (ECT) Instructions
    - Life management requests
  - Life-Prolonging Treatment
  - Organ Donation
  - Signatures



This advance directive ("AD") complies with the Virginia Healthcare Decisions Act. You are not required to use this form to create an AD. If you choose to use a different form, you should consult with an attorney or your health care provider to be sure the different form will be valid under Virginia law.

As long as it is signed and witnessed (on page 10), you may complete any or all of the parts of this AD that you want. Cross out or leave blank any parts that you do not want to use.

**VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE**
**with Sections for Medical, Mental, and End-of-Life Health Care**

I, _____ (date of birth _____), make this advance directive in case I am not able to make health care decisions for myself. This advance directive says what I do want and what I do not want for my health care.

**Section 1: Health Care Decision Maker (My "Agent")**

**A. Who I Pick to be My Agent**

I appoint _____ to make health care decisions for me when I cannot make those decisions myself.

5

# FUNCTION OVER FORM

**Any** advance directive can be crafted to include:

- Mental health medications
- Mental health & mental-health-adjacent providers
  - e.g., therapists, peer support specialist, AA/NA sponsor, case manager, dietician, psychiatrist, etc.
- Mental health hospitalization activation option
- Protest Provision
- Considerations for individuals in recovery, especially those who have recovery or wellness plans

**Any other individual instructions, preferences, or background information**

6

# CAPACITY TO MAKE TREATMENT DECISIONS & MENTAL HEALTH

**§ 54.1-2983.2. CAPACITY; REQUIRED DETERMINATIONS.**

- **Every adult shall be presumed to be capable of making an informed decision** unless he is determined to be incapable of making an informed decision...
- A determination…**may apply to a particular** health care decision, to a **specified set of** health care decisions, **or to all** health care decisions.
- **No person shall be deemed incapable of making an informed decision based solely on a particular clinical diagnosis**.

**Particularly relevant AD elements**
- Power 5 Option
- Protest provision

**CAPACITY IS NOT MONOLITHIC OR STATIC**

- E.g., Being under an emergency psychiatric hold order does not mean the person lacks capacity to make any health care decisions
- ACP is collaborative decision making -- if the person can make the decision in conversation with their provider, they can do so on paper too

7

# ACTIVATION OF MENTAL HEALTH HOSPITALIZATION POWER

- ADs are activated when a person is found to lack capacity to make needed treatment decisions
  - two physicians, or a physician and clinical psychologist
- In the case of mental health emergency, person may want their agent to have power to consent to mental health admission in a short time
- "Power 5 option" allows person to choose for quicker activation of the power by requiring just one provider (from a wider list of providers) to find lack capacity

5. To consent to my admission to or transfer to a mental health care facility when it is recommended by my health care providers, and to authorize my discharge from any such facility.

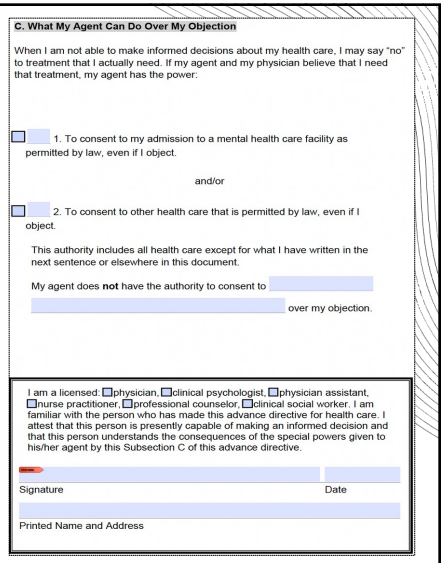
The admission can be for up to the maximum time permitted by current law. At the time I made this advance directive the maximum was ten (10) calendar days.

☐ Power 5 option: My agent may exercise this power after one of the following professionals determines that I am not able to make an informed decision about admission: an attending physician, a psychiatrist or clinical psychologist, a psychiatric nurse practitioner, a clinical social worker, or a designee of the local community services board who is trained to assess capacity.

8

# PROTEST PROVISION

- Available for mental and physical health
- The default rule in health care is that providers cannot treat over objection
  - This default rule applies even when a person is incapacitated
- Filling out the Protest Provision portion will allow the agent and providers to override the person's later objection
- A person may want to consider filling out the provision if they are worried that while in crisis they might object to treatment they would want if asked when they were not in crisis



**C. What My Agent Can Do Over My Objection**

When I am not able to make informed decisions about my health care, I may say "no" to treatment that I actually need. If my agent and my physician believe that I need that treatment, my agent has the power:

☐ 1. To consent to my admission to a mental health care facility as permitted by law, even if I object.

and/or

☐ 2. To consent to other health care that is permitted by law, even if I object.

This authority includes all health care except for what I have written in the next sentence or elsewhere in this document.

My agent does **not** have the authority to consent to _____ over my objection.

I am a licensed: ☐physician, ☐clinical psychologist, ☐physician assistant, ☐nurse practitioner, ☐professional counselor, ☐clinical social worker. I am familiar with the person who has made this advance directive for health care. I attest that this person is presently capable of making an informed decision and that this person understands the consequences of the special powers given to his/her agent by this Subsection C of this advance directive.

Signature Date

Printed Name and Address

9

# BARRIERS

- Over-focus on a singular AD form – no form is perfect, it takes time to find or create the best document for each person
- Healthcare in America has its own barriers:
  - stigma around mental health and addiction issues
  - communication between fields
  - which field takes lead for complex person
  - time for conversation
- Over reliance on assessment tools – we forget to lift our heads up and see the gaps between tools

**Sometimes we forget to ask about an individual's values, life experiences, non-medical goals of care and wellness routines, and fears or concerns**

10

# PULLING IT ALL TOGETHER

**Palliative care...**

- Characterized by needs assessment, open communication, patient-driven goal setting
- Uses holistic approach, focusing on entire person & not just illness
- Addresses social, psychological, emotional, and spiritual needs
- Together, care team and the person create care plan that takes into account personal values

**...and so does person-centered advance care planning**

https://www.masseycancercenter.org/cancer-types-and-treatments/cancer-treatments/palliative-care/what-is-palliative-care

11

# THANKS FOR ATTENDING

*www.honoringchoices-va.org*
*ejones@ramdocs.org*

*www.ilppp.org*
*HZ3J@uvahealth.org*

12