

Goal	<p>To enable designated VHA staff to provide information about advance directives and assistance in completing forms to patients who request this service, as required under VHA Handbook 1004.02, <i>Advance Care Planning and Management of Advance Directives</i>.</p>
OBJECTIVES	<p>By the end of this session, participants will be able to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Identify the policy requirements, described in VHA Handbook 1004.02, <i>Advance Care Planning and Management of Advance Directives</i>, for staff members who are responsible for providing patients with information about advance directives or assistance in completing forms when patients request these services. <input type="checkbox"/> Access and explain the content of pertinent advance care planning documents and patient education materials. <input type="checkbox"/> Discuss possible conditions and be able to answer key questions about life-sustaining treatments. <input type="checkbox"/> Explain relevant information to help patients decide whether to complete a VA advance directive and/or a state-authorized advance directive. <input type="checkbox"/> Explain relevant information to help patients decide whether to complete a Durable Power of Attorney for Health Care. <input type="checkbox"/> Explain relevant information to help patients decide whether to complete a Mental Health (Psychiatric) Advance Directive. <input type="checkbox"/> Explain relevant information to help patients decide whether to complete VA Form 10-5345, <i>Request for and Authorization to Release Medical Records or Health Information</i>. <input type="checkbox"/> Access a handout with suggested language for advance directive discussions. <input type="checkbox"/> Access a handout with key questions about life-sustaining treatments.

Trainers should compile the following documents for their presentation:

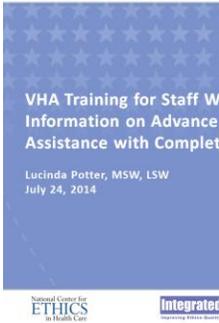
- Trainer's Guide (this document)
- Trainee Sign-in Sheet
- PowerPoint slides, *VHA Training for Staff Who Provide Information on Advance Directives and Assistance with Completing Advance Directives*
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*
- VA Form 10-0137, *VA Advance Directive: Durable Power of Attorney for Health Care and Living Will*
- VA Form 10-0137A, *Your Rights Regarding Advance Directives*
- VA Form 10-0137B, *What You Should Know About Advance Directives*
- VA Form 10-5345, *Request for and Authorization to Release Medical Records or Health Information*
- "Mental Health Care Preferences" worksheet
- Your state's advance directive (if applicable)
- Post-Test
- Certificate of Completion Template (Decide in advance if you will provide participants with this certificate of completion or if you will acknowledge training completion according to your local procedures)
- "Discussing Advance Directives with Patients" handout
- "Information for Patients: Common Life-Sustaining Treatments" handout

TRAINEE'S PACKET	<p>Trainers should compile the following materials for all training participants:</p> <ul style="list-style-type: none"> <input type="checkbox"/> PowerPoint slides, <i>VHA Training for Staff Who Provide Information on Advance Directives and Assistance with Completing Advance Directives</i> <input type="checkbox"/> VHA Handbook 1004.02, <i>Advance Care Planning and Management of Advance Directives</i> (December 24, 2013), available at: http://vaww.va.gov/VHApublishations/ViewPublication.asp?pub_ID=2967 <input type="checkbox"/> VA Form 10-0137, <i>VA Advance Directive: Durable Power of Attorney for Health Care and Living Will</i>, available at: http://vaww.va.gov/vaforms/ <input type="checkbox"/> VA Form 10-0137A, <i>Your Rights Regarding Advance Directives</i>, available at: http://vaww.va.gov/vaforms/ <input type="checkbox"/> VA Form 10-0137B, <i>What You Should Know About Advance Directives</i>, available at: http://vaww.va.gov/vaforms/ <input type="checkbox"/> VA Form 10-5345, <i>Request for and Authorization to Release Medical Records or Health Information</i>, available at: http://vaww.va.gov/vaforms/ <input type="checkbox"/> "Mental Health Care Preferences" worksheet <input type="checkbox"/> Your state's advance directive (if applicable) <input type="checkbox"/> Post-Test <input type="checkbox"/> "Discussing Advance Directives with Patients" handout <input type="checkbox"/> "Information for Patients: Common Life-Sustaining Treatments" handout <input type="checkbox"/> Training evaluation
PREPARATION CHECKLIST	<ul style="list-style-type: none"> <input type="checkbox"/> Identified and invited appropriate participants (see Attachment A). <input type="checkbox"/> Arranged for adequate space and time (approximately 90 minutes, including 15 minutes for set-up, 60 minutes for presentation, and 15 minutes for clean-up). <input type="checkbox"/> Arranged for the use of appropriate technology (laptop and projector). <input type="checkbox"/> Printed and prepared a sufficient number of trainee packets. <input type="checkbox"/> Reviewed the Trainer's Guide (this document) and familiarized myself with the materials. <input type="checkbox"/> Determined if the state in which my facility is located has a state-authorized advance directive or patients that get care at my facility live in a state that has a state-authorized advance directive. If so, I have printed sufficient copies of the advance directive and included it in the trainee packets. <input type="checkbox"/> Read VHA Handbook 1004.02, <i>Advance Care Planning and Management of Advance Directives</i> (December 24, 2013). <input type="checkbox"/> Prepared the Certificates of Completion or alternative training acknowledgment.

Trainer's Guide

OUTLINE OF TRAINING	1 Introduction.....	4 minutes
	2 Staff Responsibilities.....	8 minutes
	3 Deciding Whether to Complete a VA Advance Directive, a State-Authorized Advance Directive or Both.....	4 minutes
	4 Appointing a Health Care Agent.....	7 minutes
	5 Completing a Living Will.....	11 minutes
	6 Creating a Mental Health Advance Directive.....	4 minutes
	7 Completing a Release of Information Form.....	2 minutes
	8 Documenting, Filing, & Rescinding of Advance Directives.....	8 minutes
	9 Questions.....	9 minutes
	10 Conclusion.....	3 minutes
Total session time		60 minutes

1. Introduction (4 minutes)

<p>Slide 1</p> 	<p>SAY: Thank you, Lorn, for that introduction.</p> <p>Hello, everyone. I'm Georgina Baumgartner and I am here with my colleague, Lucy Potter. Lucy, are you there? We'll both be conducting the training today. Dr. Virginia Ashby Sharpe, Acting Deputy Director and Chief of Ethics Policy at the National Center for Ethics In Health Care is also standing by to monitor the chat box.</p>
<p>Slide 2</p> 	<p>Before we get started I would like to remind everyone about a few things. For those of you on VANTS, today's presentation can be viewed on Adobe Connect. The link to Adobe Connect can be found in TMS. For audio access today, please use the VANTS information that is shown on the Adobe Connect screen. Do not use the Adobe audio function. If you are logged in to Adobe, please mute or turn off your computer speakers and dial in to VANTS.</p>
	<p>During the call today, the VANTS lines will be muted; so, if you have questions, please use the Adobe chat feature. Due to the limited amount of time we have for this training, please refrain from using the chat function for side conversations and just use it to ask us questions. We know that people have a lot of good ideas about best practices related to advance care planning and management of advance directives, so we recommend that you set up a listerv or time to share your ideas with your colleagues to do that.</p> <p>As a reminder, this training is not an appropriate place to discuss specific cases or confidential information.</p>

Trainer's Guide

Finally, I will be referring to a number of documents and worksheets during the call today which are posted in the files section in the lower left hand of the adobe screen. You can also download them from the National Center for Ethic's in Health Care Website:

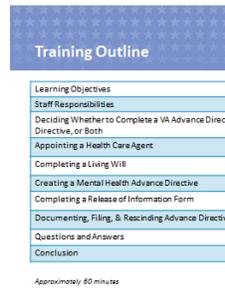
<http://vaww.ethics.va.gov/Policy/ADTraining.asp>

Let's start with some poll questions... (TALK DURING POLLS) Put up the first two polls:

1. Do you know how to access the blank advance directive form on paper and or through /iMedConsent?
2. Have you assisted a Veteran in completing an Advance Directive?

CLICK.

Slide 3



Training Outline

- Learning Objectives
- Staff Responsibilities
- Deciding Whether to Complete a VA Advance Directive, or Both
- Appointing a Health Care Agent
- Completing a Living Will
- Creating a Mental Health Advance Directive
- Completing a Release of Information Form
- Documenting, Filing, & Rescinding Advance Directives
- Questions and Answers
- Conclusion

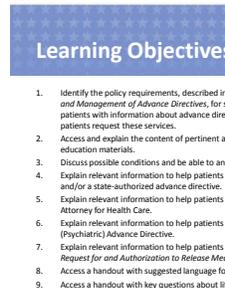
Approximately 60 minutes

SAY:

OK- let's get started. This training takes approximately one hour to complete. We will be covering the content on this slide. By the end of this training, you will be considered appropriately trained, as required by VHA policy.

CLICK.

Slide 4



Learning Objectives

1. Identify the policy requirements, described in *and Management of Advance Directives*, for patients with information about advance directives who request these services.
2. Access and explain the content of pertinent education materials.
3. Discuss possible conditions and be able to answer questions about advance directives for patients and/or a state-authorized advance directive.
4. Explain relevant information to help patients understand the role of an *Attorney for Health Care*.
5. Explain relevant information to help patients understand the role of a *(Psychiatric) Advance Directive*.
6. Explain relevant information to help patients understand the role of a *Request for and Authorization to Release Medical Information*.
7. Access a handout with suggested language for patients.
8. Access a handout with key questions about the training.
9. Access a handout with key questions about the training.

SAY:

Our goal is that by the end of the call today, you will have achieved the learning objectives outlined in this slide. Topics include identifying policy requirements, using education materials, discussing life-sustaining treatments. The objectives also include being able to explain relevant information to patients to help them decide whether or not to complete a (1) VA advance directive and/or a state-authorized advance

Trainer's Guide

	<p>directive,(2) a durable power of attorney for health care (3)mental health advance directives and (4) VA’s release of information form.</p> <p>CLICK.</p>
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2. Reviewing Staff Responsibilities (8 minutes)

<p>Slide 5</p> <div style="background-color: #4a7ebb; color: white; padding: 5px; margin-top: 10px;"> <p>Staff Responsibilities</p> </div> <ol style="list-style-type: none"> 1. Give patients pertinent educational material 2. Encourage patients to discuss their preferences for health care with their loved ones 3. Explain the benefits of advance care planning directives (especially for patients at high risk of losing decision-making capacity) 4. Highlight the particular benefits of appointing a health care agent (especially if a problem related to the agent is anticipated) 	<p>SAY:</p> <p>As you know, an advance directive is a written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that the individual becomes unable to make those decisions</p> <p>You are here today because you have been designated the responsibility of providing information about advance directives to patients and the responsibility of providing assistance with completing advance directive forms to patients who request this service. In order to achieve this requirement, you are responsible for doing all of the following:</p> <ol style="list-style-type: none"> 1. You need to ensure that the patient understands what advance care planning means and what an advance directive is. You are responsible for giving patients educational materials for example, VA Forms 10-0137 A and B. (These documents are attached to the Adobe connect window.)
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VA Form 10-0137A is entitled *Your Rights Regarding Advance Directives*.

VA Form 10-0137B is entitled *What You Should Know About Advance Directives*. *Let me talk about 10-0137B first.*

-PAUSE –

VA form 10-0137B What You Should Know About Advance Directives is written in a Frequently Asked Questions format, and should be given to patients who request additional information about advance care planning or advance directives. [This document is labeled #1 in the files section of the Adobe.]

VHA Handbook 1004.02 identifies requirements related to notification and screening regarding advance directives. Notification means that all patients are given written notification, stating their right to accept or decline medical treatment, to designate a Health Care Agent, and to document their treatment preferences. Providing patients with a copy of VA form 10-0137A, *Your Rights Regarding Advance Directives* satisfies this requirement. [This document is also in the files section of Adobe and is labeled #2.] Advance directive screening ensures that all patients and CLC residents must be asked if they have an advance directive or a mental health advance directive.

Notification and screening may be performed by the admitting clerk or other designated staff, not necessarily the social worker. The Handbook lists several situations in which screening is

required. It is important to note that screening is required as part of hospital discharge planning when a patient is discharged to a long-term care or rehabilitation facility in the community. Social workers often lead the discharge planning process so, it is important to be aware of this requirement.

The Ethics Center recently developed a new notification and screening template that can be installed at all sites via a Vista software patch. It is available on the Center's website. The template allows VA staff to document if written notification about advance directives was provided to the patient, if the patient has an advance directive and if it's on file, and if the patient's advance directive contains information about mental health preferences. There is an FAQ document about the template called "Frequently Asked Questions: Advance Directive Notification and Screening (ADNS) Template." This is also in the files section of Adobe and is labeled as #3.

2. Another responsibility you have is to encourage patients to discuss their preferences for future health care with their loved ones. Even if the patient doesn't want to complete an advance directive, talking about their wishes with their loved ones—especially those who would be selected as surrogates—can help them think about what kind of care they might want in the future. Often, friends and family members can ask questions or tell the patient things that will make them think about their wishes in a different way. In addition, a patient's loved one may better understand the wishes of the patient following such a conversation.

3. You also need to explain the benefits of advance care planning and the benefits of advance directives. This is especially important for patients who are at high risk of losing decision-making capacity, such as patients with cerebrovascular disease, early dementia, serious mental illness, or other life-limiting illnesses. People have different goals for their care and different opinions about the kind of care they may want. Advance care planning helps people understand themselves and helps them give guidance to their loved ones.

4. Another responsibility is to highlight the benefits of appointing a health care agent, especially if a problem related to surrogacy is anticipated. While appointing a health care agent is optional and voluntary, if someday a patient can't make decisions on their own, VA will appoint a surrogate for them according to VA's surrogate hierarchy. The person who is authorized to serve as surrogate under VA's policy may or may not be the person the patient wants to make decisions on their behalf. Lucy will discuss the benefits of appointing a health care agent in more detail later in the presentation.

CLICK.

5. Describe the limitations of advance directives
6. For patients who already have an advance directive in their electronic health record, review the advance directive to ensure it is up to date and states the patient's intentions clearly
7. If the patient has more than one advance directive in their electronic health record, ask the patient to indicate which one remains active and which, if any, needs to be rescinded
8. Document the advance care planning discussions with the patient and summarize the significant content

SAY:

5. You also need to explain the limitations of advance directives to patients. For example, most advance directive forms give the patient a few specific examples of clinical situations when life-sustaining treatments might be needed to help the patient imagine the kind of care they would want. While these situations are helpful, no form can capture all of the possible clinical situations that a patient might experience. Another limitation is that advance directives are limited to the patient's preferences at a point in time, but these preferences may change over time. Also, any patient preferences that are expressed in an advance directive will need to be interpreted by the patient's providers and loved ones when decisions need to be made. Their interpretations may be quite different from what the patient intended. For these reasons, patients may decide against attempting to specify treatment preferences and instead merely designate a health care agent who they trust to make decisions for them.

6. For patients who already have an advance directive in their electronic health record, you need to review the advance directive with the patient to ensure it is up to date and that it states the patient's intentions clearly. If a patient wants to update or revise a VA advance directive, a new one needs to be created and documented, and the old one must be rescinded. To rescind an advance directive, please follow the procedures we will outline later in this presentation.

7. If the patient has more than one advance directive in their electronic health record, you need to ask the patient to indicate which one remains active, and which, if any, needs to be rescinded.

8. Last, you need to document your advance care planning discussions with the patient and summarize the significant content. There are three approved progress note titles for documenting advance care planning discussions and advance directives, which we will be going over in more detail later in this presentation.

CLICK.

Slide 7

PCP Responsibilities for Advance Care Planning

1. Raising the issue of ACP with all patients who have decision-making capacity, explaining that they do this with all of their patients.
2. Initiating ACP conversations periodically:
 - At intervals no longer than 3 years,
 - Whenever the PCP observes a significant change in the patient's status, and
 - At the earliest opportunity after a new or revised advance directive is entered into the patient's record.
3. Initiating ACP conversations more frequently with patients who are at high risk of losing decision-making capacity.
4. Assisting or referring patients who request more information or assistance with completing forms.

SAY:

VHA policy also establishes requirements for the primary care provider or Patient Aligned Care Team (PACT) related to advance care planning. Please note that the primary care provider may delegate these responsibilities to other staff. This training is intended to assist Social Workers and others to be prepared to take on these responsibilities. So, here is what staff members must do – this is the PCP, PACT, or other staff members who have had responsibilities delegated to them: They must raise the issue of advance care planning with all patients who have decision-making capacity, explaining that they do this with all of their patients. These conversations may be brief, or more extensive, depending on the patient's circumstances. They are also responsible for periodically initiating conversations about advance care planning (at intervals no longer than three years) and whenever there is a significant change in the patient's health status. Advance care planning conversations should be initiated more frequently with patients who are at high risk of losing decision-making capacity and at the earliest opportunity after a new or revised advance directive is entered into the patient's record.

Last, for patients who request more information or assistance completing advance directive forms, the primary care provider may personally provide the information or assistance or may refer the patient to another qualified individual. Providing information or assistance includes all of the responsibilities described earlier.

Instructions to trainer: If your audience includes primary care providers, insert information on how to submit referrals according to local procedures.

NOW LUCY IS GOING TO TALK ABOUT COMPLETING A VA ADVANCE DIRECTIVE, A STATE-AUTHORIZED ADVANCE DIRECTIVE OR BOTH.

Trainer's Guide

VHA Training for Staff Who Provide Information on Advance Directives and Assistance with Completing Advance Directives (7/16/14)

CLICK

3. Deciding Whether to Complete a VA Advance Directive, a State-Authorized Advance Directive or Both (4 minutes)

Slide 8

Deciding Whether to Complete a VA Advance Directive or a State-Authorized Advance Directive

Explain to patients that:

1. States have different laws about advance directives that apply outside of VA
2. Patients may complete a VA advance directive, a state-authorized advance directive, or both
3. The VA advance directive contains details that state-authorized advance directives don't include
4. Patients can attach worksheets or other documents to their advance directive to further clarify their preferences

SAY:

Thank you, Georgina. Hello, everyone. Please feel free to refer to VA Form 10-0137, which is VA's advance directive [Document #4]. I'll be talking about different sections of it in my part of the presentation.

- PAUSE -

Instructions to trainer: instruct participants to take out the VA AD and state-authorized advance directive if your facility is located in a state that has a state-authorized advance directive or patients that receive care at your facility live in a state that has a state-authorized advance directive.

When talking with patients about advance directives, you should help them decide whether they should fill out VA's advance directive, their state's advance directive, or both. A state-authorized advance directive is an advance directive document that is legally recognized by a particular state. *Advantages* of the VA advance directive include that it contains details that some state-authorized advance directives do not contain, and it allows the patient to attach worksheets or other documents for further clarification of their preferences.

A *disadvantage* of the VA advance directive is that—depending on the state—it may not be recognized as a legally binding document in non-VA settings. If the patient lives in a state that does not recognize the VA advance directive, your patient should consider completing both a VA advance directive AND their state's advance directive. If the patient completes both types of advance directives, tell them to make sure that the two documents are consistent with each other. This will ensure that they will have a legal advance directive if they are admitted to a hospital outside of the VA system. Questions about the validity of state-authorized advance directives should be referred to your Regional Counsel.

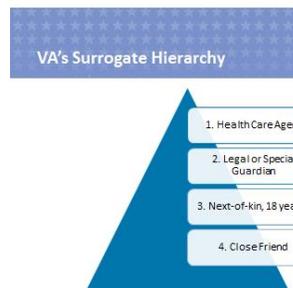
Trainer's Guide

VHA Training for Staff Who Provide Information on Advance Directives and Assistance with Completing Advance Directives (7/16/14)

	CLICK.
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4. Appointing a Health Care Agent (7 minutes)

Slide 9



SAY:

Page two of the VA Advance Directive is the “Durable Power of Attorney for Health Care” section. A “Durable Power of Attorney for Health Care” is a legal document in which the patient can appoint a health care agent. Explain to the patient that a health care agent is a person they can select to make health care decisions on their behalf if, in the future, they lose the ability to make their own health care decisions.

Explain to the patient that if they were to lose decision-making capacity, VA providers would select a surrogate to make health care decisions. It is important to review the surrogate hierarchy with the patient and determine if the person who is authorized to serve as surrogate under VA’s policy is the person the patient wants to make decisions on their behalf. If not, encourage the patient to complete a Durable Power of Attorney for Health Care.

Let’s take a few moments to discuss VA’s surrogate hierarchy, which is specified in VA’s informed consent policy – VHA Handbook 1004.01. In VA, if the patient lacks decision-making capacity the surrogate is authorized to make health care decisions on behalf of the patient in the following order of priority:

- (1) Health Care Agent;
- (2) Legal guardian or special guardian – in other words, someone appointed by the court to make health care decisions for the patient;
- (3) Next-of-kin. The next-of-kin is a relative, 18 years of age or older, in the following order of priority: spouse, adult child, parent, sibling, grandparent, and grandchild. And back to the surrogate hierarchy--

Trainer’s Guide

(4) Close friend.

A “close friend” is considered any person 18 years or older who has shown care and concern for the patient’s welfare and is familiar with the patient’s activities, health, religious beliefs, and values. The close friend must present a signed, written statement that will be placed in the patient’s electronic health record describing (with specific examples) that person’s relationship to, and familiarity with, the patient. Social workers, or other staff, must verify, in a signed and dated progress note, that this requirement has been met.

Explain to the patient that in VA, the authorized surrogate is the person at the highest level of the VA hierarchy who is willing and able to serve in that role. Also note that the person who is authorized to serve as surrogate in VA is not necessarily the same person who would serve as surrogate if the patient were receiving care at a non-VA facility. In a non-VA facility, the surrogate would be determined by state law, whereas in VA, the surrogate is determined by Federal law and VA policy.

Let’s take a few moments to discuss the spouse as surrogate. The spouse is the first in the priority list under “next-of-kin” and so is often the authorized surrogate if the patient has not designated a health care agent. On June 26, 2013, the Supreme Court ruled that Section 3 of the Defense of Marriage Act (DOMA) is unconstitutional. Based on that decision, VA is now able to treat all married individuals equally, as legally recognized spouses, regardless of gender. In practice, this means that VA personnel should treat a Veteran’s same-sex spouse just as they would a Veteran’s opposite-sex spouse.

	<p>VA is not necessarily able to accord this same legal recognition to unmarried partners. An unmarried partner would fall under the fourth-tier of the priority list – as a “close friend.” Patients can ensure that their preferred surrogate is at the top of VA’s surrogate priority list by appointing that person as their Health Care Agent in a Durable Power of Attorney for Health Care.</p> <p>CLICK.</p>
<p>Slide 10</p> 	<p>SAY:</p> <p>There are many reasons why patients might want to choose a particular individual as their health care agent. Some patients have no close family members or are estranged from their family members. Some have multiple surrogates at the same priority level, such as several adult children, but think that one would be a better decision-maker. Some disagree with the beliefs of their family members, or are more comfortable telling a particular person how they feel about future health care choices. Some expect that their family members will disagree with each other so the patient wants to let everyone know ahead of time who should represent them. Others may want their partner (to whom they are not married) to be their surrogate. In all of these scenarios, the patient can make sure their preferred surrogate is at the top of VA’s surrogate hierarchy by appointing that person as their health care agent. Once a patient has appointed a health care agent, they need to tell that person—and also tell others—who they have chosen. It can be helpful to provide patients with examples of problems with surrogacy in order to emphasize the benefits of appointing a health care agent.</p> <p>POLL</p>

So that you can experience how these decisions are made, take a few moments to think about who you would identify as your health care agent. Please write your answer in the poll question on the screen. You do not have to identify any specific names, just their role such as spouse, friend, brother, and so on

Post poll question: 3. Who would you select as your health care agent?
[Comment on answers coming in...]

It looks as if there is some variety here. As we can see people have different ideas about who they would want to make decisions for them if they do not have decision-making capacity. This illustrates how important it is to designate a health care agent.

CLICK.

5. Completing a Living Will (11 minutes)

Slide 11

Completing a Living Will

- Start by having a general conversation about health care preferences with the patient if they are sick or injured and couldn't communicate.
1. Ask what would be meaningful or important to them if they were sick or injured and couldn't communicate.
 2. Provide examples of what people might want to happen, such as to be as comfortable as possible, to live as long as possible, or to spend time with loved ones. Ask the patient what would be important to them. Also give them some examples of what people might want to avoid, such as being unable to communicate, being in pain, or being separated from loved ones. Encourage the patient to discuss experiences they have had with family or friends and how that relates to what they would want. If there is a particular situation that is relevant to the patient, be sure to explore that with them.
 3. Provide examples of different medical situations in which they would not be able to make their own health care decisions. Some examples are the following:

SAY:

The living will section is on page 3 of the VA advance directive.

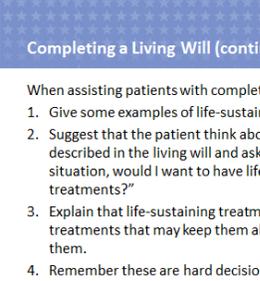
A living will is a legal form that states the kinds of treatments you would, or would not want, if you became ill and could not decide for yourself.

For patients who want assistance completing a living will, start by having a general conversation about health care preferences. Ask them to think about what would be meaningful or important to them if they were sick or injured and could not communicate for themselves. Give them some examples of what people might want to happen, such as to be as comfortable as possible, to live as long as possible, or to spend time with loved ones. Ask the patient what would be important to them. Also give them some examples of what people might want to avoid, such as being unable to communicate, being in pain, or being separated from loved ones. Encourage the patient to discuss experiences they have had with family or friends and how that relates to what they would want. If there is a particular situation that is relevant to the patient, be sure to explore that with them.

After the patient has thought about what is important to them if they were sick or injured and could not communicate their preferences, describe some medical situations in which they would not be able to make their own health care decisions. Some examples are the following:

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VHA Training for Staff Who Provide Information on Advance Directives and Assistance with Completing Advance Directives (7/16/14)

	<ul style="list-style-type: none"> - You are unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery; - You have permanent, severe brain damage that makes you unable to recognize family or friends (for example, severe dementia); - You have a permanent condition so that other people must help you with your daily needs (for example, eating, bathing, toileting); <p>Encourage the patient to relate the preferences they previously described with these different examples.</p>
<p>Slide 12</p> 	<p>CLICK</p> <p>SAY:</p> <p>Finally, help the patient translate their preferences for life-sustaining treatments in certain situations into the living will. Explain to the patient that the living-will section of the VA advance directive lets them write down how they want to be treated in case they are not able to decide for themselves anymore. Its purpose is to help others make decisions about their care. Start by giving the patient some examples of life-sustaining treatments, such as cardiopulmonary resuscitation or CPR, a breathing machine (also called mechanical ventilation), kidney dialysis, and a feeding tube (also called artificial nutrition and hydration). Then suggest that the patient think about each situation described and encourage them to ask themselves, “in that situation, would I want to have life-sustaining treatments?” Patients should decide, for each situation, whether they would want life-sustaining treatments, whether they would <i>not</i> want life-sustaining treatments, or whether they are not sure and it would</p>

depend on the circumstances. Patients can complete some, all, or none of this section.

During this conversation with the patient, tell them that life-sustaining treatments are medical treatments that may keep people alive longer but that do not cure them. For general questions about life-sustaining treatments you can refer to the handout entitled “Information for Patients: Common Life-Sustaining Treatments.” [Document #5]. If patients have more specific questions about life-sustaining treatments, be sure to direct them to their primary care provider.

Remember, these are difficult decisions to make and patients always have the option to indicate that they are not sure what they would want.

CLICK.

6. Creating a Mental Health Advance Directive (4 minutes)

Slide 13

Creating a Mental Health Advance Directive

1. All patients have the right to express medical and mental health care preferences.
2. Patients with serious mental illness (making capacity) may want to document preferences in a mental health advance directive.
3. VA Form 10-0137 is a mental health advance directive if it contains mental health preferences attached pages (attached pages must be initialed, dated, and attached).
4. More than half of all states have adoption statutes designed for psychiatric patients.

SAY:

The last section I am going to talk about is creating a mental health advance directive. Feel free to turn to Part B of the living will section of the VA advance directive which is on page 3. You can also refer to the Mental Health Preferences worksheet.

- PAUSE -

All patients have the right to express, in advance, their medical AND mental health care preferences in case they lose decision-making capacity. Patients may want to document their mental health preferences such as medications for their mental health conditions that have worked for them in the past and that they would want again in the event that they cannot communicate their preferences. Another example is that patients may want to document their preferences for mental health facilities or hospitals.

VA does not have a separate mental health advance directive. VA Form 10-0137 is a mental health advance directive if it contains mental health preferences in Part Three B or if additional pages are initialed, dated, and attached to it. Patients can use the Mental Health Care Preferences worksheet to document mental health care preferences. The worksheet is available on the Ethics Center's website. This Mental Health Care Preferences worksheet is not mandated for use. Facilities can use locally created worksheets, but use of the Ethics Center's worksheet is recommended for standardization. [Document #6] Again, please note that all pages attached as an addendum to the advance directive must be initialed and dated.

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Completing Part Three B of the VA advance directive achieves the Joint Commission's standard regarding mental health advance directives. That is, organizations that serve adults with serious mental illness are required to support adults' decisions about how care, treatment, or services are to be delivered during times when he or she is unable to make such decisions. Additionally, more than half of all states have adopted separate mental health advance directive statutes designed for psychiatric patients who experience fluctuating decision-making capacity.

Now, I'll turn the rest of the presentation over to Georgina.

CLICK.

7. Completing a Release of Information Form (2 minutes)

Slide 14

Completing a Release of Information

1. VA Form 10-5345 is VA's Release of Information form.
2. If the patient's health record contains information about substance abuse, sickle cell anemia, tuberculosis, or alcohol abuse, tell the patient that VA Form 10-5345 specifically authorizes the release of this information to their surrogate, or the surrogate's health care decision for the patient's health care.

SAY:

Thank you, Lucy. Now we are going to talk about completing a release of information form and the nuts and bolts of implementing advance directives including documenting, filing, and rescinding an advance directive.

VA Form 10-5345 is VA's Release of Information form and is entitled "Request for and Authorization to Release Medical Records or Health Information." This is number 7 in the files section of the Adobe. Patients should complete this form if they have health information concerning substance abuse, alcohol abuse, Human Immunodeficiency Virus (HIV) infection, and/or sickle cell anemia that they want family members or their surrogate to know about. Information about these health conditions is protected by 38 US Code, Section 7332 and is shared with family members or surrogates if the patient has completed a VA Form 10-5345. However, there is an exception! If a health care professional (HCP) deems it necessary to share protected information with a surrogate in order for that surrogate to make an informed health care decision about the patient's care, the HCP can share this protected information with the surrogate even if the patient has not completed a VA Form 10-5345.

CLICK.

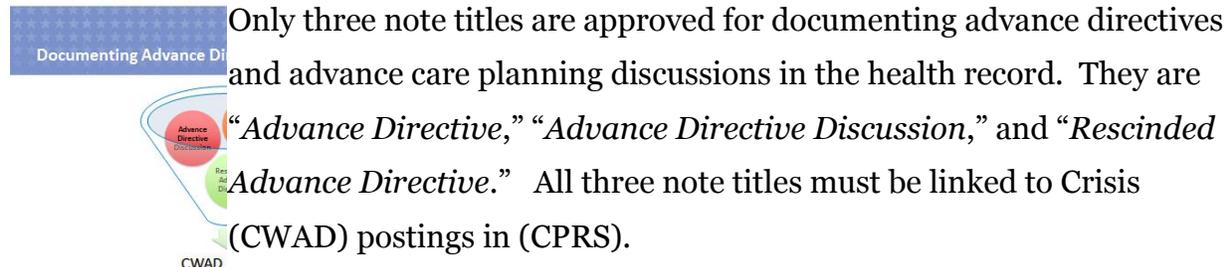
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8. Documenting, Filing, & Rescinding (8 minutes)

Slide 15

SAY:



Only three note titles are approved for documenting advance directives and advance care planning discussions in the health record. They are “*Advance Directive*,” “*Advance Directive Discussion*,” and “*Rescinded Advance Directive*.” All three note titles must be linked to Crisis (CWAD) postings in (CPRS).

The “*Advance Directive*” note title is used only to indicate that an advance directive document has been entered into the electronic record. An “*Advance Directive*” note is generated automatically when an advance directive is completed through iMedConsent™. The “*Advance Directive*” note title is also used when an advance directive is scanned into the electronic health record.

Staff who conduct advance care planning discussions with patients should use the “*Advance Directive Discussion*” note title to document their discussions. If the discussion pertains to a particular advance directive that was already in the health record, an addendum to the relevant “*Advance Directive*” note may also be used to document the discussion.

The “*Rescinded Advance Directive*” note title is used to document the patient’s revocation of an advance directive and to document that the advanced directive that is associated with that note title is invalid. We will be going over this topic in a minute.

CLICK.

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Slide 16

SAY:

Filing Advance Directives Record

Electronic filing

VA form
electron
iMedConsent
Directly
to Vista

Hard copy filing

Paper for
record
The scan
Advance

Advance directives can be completed electronically using iMedConsent™, or completed on paper and scanned into the electronic health record. When iMedConsent™ is used, the software program helps the patient electronically complete and sign VA Form 10-0137. The program then automatically saves the signed document to Vista Imaging and auto-generates the “Advance Directive” progress note.

Advance directive forms that are completed by the patient on paper need to be promptly scanned into the electronic health record through Vista Imaging. There must be an accompanying progress note titled “Advance Directive.” Not all staff members have ready access to scanners, so this can cause a delay in filing the advance directive. Because Advance Directives are legal documents used to inform essential clinical decisions, facilities should have local processes in place for ensuring these important documents are scanned quickly. If you plan to deliver this training locally, which we strongly encourage, you should tailor this section of the presentation to include information about local procedures for filing advance directives in the electronic health record.

CLICK.

Slide 17

SAY:

Rescinding Advance Directive

- Patients with decision-making capacity may revoke an advance directive at any time.
 - Write an addendum to the note
 - Request the note title be “Rescinded Advance Directive”
 - If appropriate, help the patient complete the advance directive

A patient who has decision-making capacity may revoke their advance directive at any time. Revocation occurs when the patient (or another person acting at the patient’s direction and in the patient’s presence) cancels, defaces, tears, or otherwise destroys the original or paper copy of the document. Revocation also occurs when a patient gives a written or verbal statement expressing the intent to revoke.

To ensure that documents in the patient’s electronic health record are

consistent with their health preferences, you must do all of the following whenever a patient revokes an advance directive:

1. Write an addendum to the “*Advance Directive*” progress note associated with the directive that the patient is revoking. State that the directive, including the date it was signed, was revoked and describe the discussion with the patient that resulted in revocation;
2. Request that the responsible party (typically, the Chief of Health Information Management Service) changes the progress note title associated with the revoked advance directive to “*Rescinded Advance Directive.*” You and your staff may find it helpful to implement a quality assurance activity at the local level to ensure that revoked advance directives are being appropriately retitled.
3. File a new advance directive, if applicable, with the progress note title “*Advance Directive*”

As a reminder, a patient may have more than one valid advance directive. For example, a patient living in New York may wish to have a New York state-authorized advance directive in addition to a VA advance directive. A patient may not, however, have more than one **VA** advance directive at the same time. If a new VA Form 10-0137 is entered in the record, all previous versions of VA Form 10-0137 are invalidated.

CLICK.

9. Questions (9 minutes)

Slide 18



SAY:

We have covered a lot of material today and now we'd like to address some of your questions.

If we do not get a chance to answer your question during this session or you have a question after the session, we ask that you review the FAQ document that is posted in the files section on the lower left hand side of the screen- that's document # 8 and it is "Frequently Asked Questions – VHA Handbook 1004.02: Advance Care Planning and Management of Advance Directives." It is also posted on the Ethics Center's website. If the FAQ document does not address your question, please send your question to me at Georgina.Baumgartner@va.gov

First, I'd like to answer some questions that have come up during previous training calls. We actually put these questions on the FAQ document that I mentioned.

[Read Q&A

19. "Can a VA Staff member be identified as the Health Care Agent (HCA) on a VA patient's advance directive?"

VHA policy is silent on the question of whether a VA staff member can serve as a HCA for a veteran who receives care at VA. Patients have the right to select whomever they would like to be their HCA. However, from an ethical point of view, selecting a VA staff member has the potential to create a conflict if the staff member who is chosen to act on behalf of the veteran as HCA is also involved in providing treatment for the veteran. For example a nurse or physician assistant appointed as HCA might be instructed by a physician to carry out treatment orders

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that the HCA knows are inconsistent with the veteran's wishes. Similarly, it would not be ethically appropriate for a VA social worker serving as HCA, to assist the veteran in completing an advance directive. It is recommended, therefore, that if a veteran wishes to choose a VA staff member as HCA, that staff member not be directly involved in providing care for the veteran now or in the future. A determination of whether the staff member is or would be part of the veteran's treatment team should be made prior to designating the staff member as HCA. It is important that social workers and other providers who assist veterans to complete advance directives help the veteran understand these potential problems.

30. Who can be a witness to the patient's completion of a VA advance directive?

VA Form 10-0137 must be signed by the patient in the presence of two witnesses. Neither witness may knowingly be named as a beneficiary in the patient's will, be appointed as a HCA in the advance directive, or be financially responsible for the patient's care. No employee of the VA facility in which the patient is being treated may serve as a witness, unless they are family members, non-clinical employees (e.g., Medical Administration, Voluntary Service, Environmental Management Service) or employees from the Chaplain Service, Psychology Service, or Social Work Service. If the patient chooses to have the document notarized, then the notary can serve as one of the two required witnesses. (In general, a clinical employee asked to serve as a witness shouldn't also be involved in making treatment recommendations for the patient.)

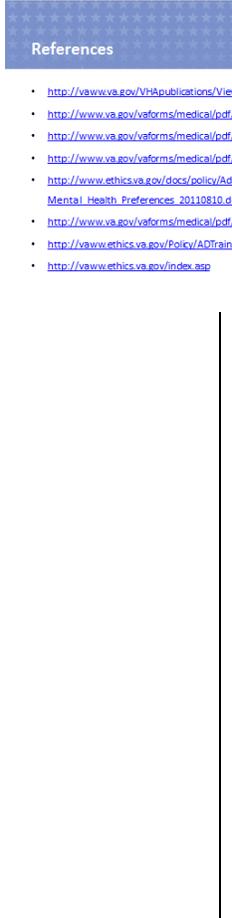
Dr. Virginia Ashby Sharpe, Acting Deputy Director and Chief of Ethics Policy at the National Center for Ethics in Health Care, who will help me to address a few questions that came in through the chat.

ASHBY HANDS IT BACK OVER TO Gina/LUCY.....

Thank you everyone for your questions.

CLICK.

10. Conclusion (3 minutes)

<p>Slide 19</p>  <p>References</p> <ul style="list-style-type: none">• http://www.va.gov/VHApublications/View• http://www.va.gov/vaforms/medical/pdf/• http://www.va.gov/vaforms/medical/pdf/• http://www.va.gov/vaforms/medical/pdf/• http://www.ethics.va.gov/docs/policy/AgMental_Health_Preferences_20110810.doc• http://www.va.gov/vaforms/medical/pdf/• http://www.ethics.va.gov/Policy/ADTrain• http://www.ethics.va.gov/index.asp	<p>SAY:</p> <p>So, I'd like to take care of a few more things before we wrap up. First, there are two more documents that I'd like to call your attention to, numbers 10 and 11 in the files section of the Adobe. Number 10 is an advance care planning reference that was developed for this training that and is on the Ethics Center website. It's called "Discussing Advance Directives with Patients." It provides sample language to help you fulfil policy requirements while also developing your personal skills for discussing advance directives with patients. Finally, document # 11 is the Handbook on advance directives—this was mentioned early on in the training-- Handbook 1004.02 Advance Care Planning and Management of Advance Directives.</p> <p>This is a slide that highlights our reference materials. We encourage you to access them online and use them in your practice.</p>
<p>Slide 20</p>  <p>THANK YOU</p> <p>National Center for ETHICS in Health Care</p> <p>IntegratedE</p>	<p>Before we conclude, please answer two final poll questions...</p> <p>Put up</p> <ol style="list-style-type: none">4. Did you learn information in today's call that will be helpful to you in performing aspects of your job?5. Are there any other advance directive topics that you are

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interested in learning more about?

Thank you for participating in this training. I hope that it was valuable for you.

As I mentioned, we encourage you to tailor this presentation to match your local processes and to deliver the training at your facility. All of the materials that were referenced today, in addition to a “trainer’s guide” with a script are available on the Ethics Center website. If you go to our Policy page, the very first section is about Advance Care Planning and Management of Advance Directives. The seventh bullet down is “VHA Training for Staff Who Provide Information and Assistance with Completing Advance Directives.” If you click on that bullet, there are several training tools to use. You may notice that there is a post-test for this training on that page. You do not have to complete the post-test to receive a certificate of completion for today’s training, but the post test can be used if you plan to offer this training locally. It’s a good idea to take a look at the post-test just to ensure that you are able to answer each question and then follow up on any of the questions that you may not be sure about.

Please also take a few minutes to complete the evaluation for this training in TMS. The window for evaluation completion is 30 days. After you’ve completed the evaluation you will be able to access your certification of completion. Please follow the directions in TMS.

This training will be offered again on December 3, 2015. Please let your colleagues know! Again, thank you for participating and each of you is now considered “appropriately trained” to provide information about advance directives and provide assistance in completing advance directive forms.

