

Person Centered Care

How is it done?


Regis College President's Lecture Series

4/11/24

Kellie LaPierre, DNP, GNP-BC

Person-Centered Care is defined as:

- Care that's guided and informed by individual's goals, preferences, and values
 - Success measured by self-reported outcomes
 - Integrated and coordinated care across health systems, providers, and care settings
 - Manages Chronic and Complex conditions
 - Joint decision making between provider and individuals
 - Relationships built on trust and a commitment to long-term well-being
- (CMS, 2024)



Focus of Person-Centered Care:

- Holistic Care
- Individualized
- Includes family & significant others
- Collaborative
- Empowering
- Focused on Prevention, Promotion of Health, and Individual Choice
- When planning and delivering care, emphasis is on developing relationships before completing tasks

American Association of College of Nursing (AACN)

The Center for Medicare and Medicaid Services (CMS) supports **Person-Centered Care** as essential in providing quality care





Person-Centered Care Example

Jane is a 80 year old married female in good health. She is seeing her nurse practitioner for her yearly physical. As an excellent nurse practitioner, you ask her if she has identified who she would like to have as her health care proxy and if she has completed an advanced directive.

What's the difference between Advanced Care Planning & Advanced Directives?

- ▶ **Advanced Care Planning** is the ongoing process of planning for future medical care
 - ▶ What you want and also what you don't want
 - ▶ Reflection and documentation of personal values & goals
- ▶ **Advanced Directive** are legal documents that provide instructions for future medical care
- ▶ Examples of **Advanced Directive** Documents include:
 - ▶ Health Care Proxy - Identification of proxy/decision-maker to make decisions if you are not able to
 - ▶ Durable Power of Attorney for Health Care
 - ▶ Durable Power of Attorney (need a lawyer to complete)
 - ▶ MOLST
 - ▶ Living Will
- ▶ Documents only go into effect when an individual cannot communicate their wishes

Advanced Care Planning

Where do you start?

- Initiate discussions early on with individuals to allow them to share their “wishes” with loved ones when they are capable
- Always ask if they have completed any documents?”
- Who is listed as the health care proxy?
 - Do they have an alternate listed?

Provide resources for the family to start educating themselves regarding decision that need to be made in the future

- *Hard Choices for Loving People*
 - <https://Hardchoices.com>
- *5 WISHES*
 - <https://www.fivewishes.org/for-myself/>
- *Medical Order for Life Sustaining Treatment*
 - <https://molst-ma.org>
- *Honoring Choices – MA*
 - <https://www.honoringchoicesmass.com/>
- *Conversation Project*
 - <https://theconversationproject.org/>

MA Health Care Proxy Form

YOUR BIRTH DATE (m/d/yr)

____/____/____

MASSACHUSETTS HEALTH CARE PROXY

1 I, _____, residing at _____
(Principal: PRINT your name)

(Street) (City/town) (State/ZIP)

appoint as my **Health Care Agent**: _____
(Name of person you choose as Agent)

of _____
(Street) (City/town) (State/ZIP)

Agent's tel (h) _____ (w) _____ E-mail _____

OPTIONAL: If my agent is unwilling or unable to serve, then I appoint as my **Alternate Agent**:

(Name of person you choose as Alternate Agent)

of _____
(Street) (City/town) (State/ZIP) (Phone)

2 My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, *if any*, you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

3 **Signed:** _____ **Date:** ____/____/____ (mo/day/yr)

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

(Name)

(Street)

(City/town)

(State/ZIP)

4 **WITNESS STATEMENT:** We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document. In our presence, on this day ____/____/____ (mo / day / yr).

Witness #1 _____ Witness #2 _____
(Signature) (Signature)

Name (print) _____ Name (print) _____

Address _____ Address _____

MOLST

What is MOLST ?

“Medical Orders for Life-Sustaining Treatment” is a *discussion process* between a patient and his or her physician, resulting in the completion of a *MOLST form* containing medical orders about:

- Resuscitation
- Ventilation
- Transfer to hospital
- Plus other life-sustaining treatments

➡ Other life-sustaining treatments include:

- Artificial Nutrition
- Artificial Hydration
- Dialysis

Massachusetts MOLST

<http://www.molst-ma.org/>

MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT



(MOLST) www.molst-ma.org

Patient's Name _____

Date of Birth _____

Medical Record Number if applicable: _____

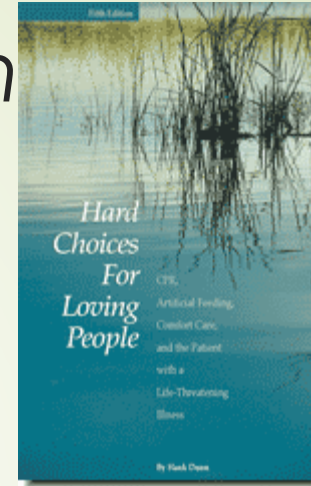
INSTRUCTIONS: Every patient should receive full attention to comfort.

- This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the patient's clinician.
- Sections A-C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
- If a section is not completed, there is no limitation on the treatment indicated in that section.
- The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A	CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest
Select one circle →	<input type="radio"/> Do Not Resuscitate <input type="radio"/> Attempt Resuscitation
B	VENTILATION: for a patient in respiratory distress
Select one circle →	<input type="radio"/> Do Not Intubate and Ventilate <input type="radio"/> Intubate and Ventilate
Select one circle →	<input type="radio"/> Do Not Use Non-invasive Ventilation (e.g. CPAP) <input type="radio"/> Use Non-invasive Ventilation (e.g. CPAP)
C	TRANSFER TO HOSPITAL
Select one circle →	<input type="radio"/> Do Not Transfer to Hospital (unless needed for comfort) <input type="radio"/> Transfer to Hospital
PATIENT <small>or patient's representative signature</small>	Select one circle below to indicate who is signing Section D: <input type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. *A guardian can sign to the extent permitted by MA law. Consult legal counsel with questions about guardian's authority.
D	<small>Required - Select circle and fill in every line for valid orders</small>
	Signature of Patient (or Person Representing the Patient) _____ Date of Signature _____ Legible Printed Name of Signer _____ Telephone Number of Signer _____
CLINICIAN signature	Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.
E	<small>Required - Fill in every line for valid orders</small>
	Signature of Physician, Nurse Practitioner, or Physician Assistant _____ Date of Signature _____ Legible Printed Name of Signer _____ Telephone Number of Signer _____
Optional <small>Expiration date and other patient care contacts</small>	This form does not expire unless expressly stated. Expiration date (if any) of this form: _____ Health Care Agent Printed Name _____ Telephone Number _____ Primary Care Physician Printed Name _____ Telephone Number _____
SEND THIS FORM WITH THE PATIENT AT ALL TIMES. <small>HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.</small>	

Hard Choices for Loving People

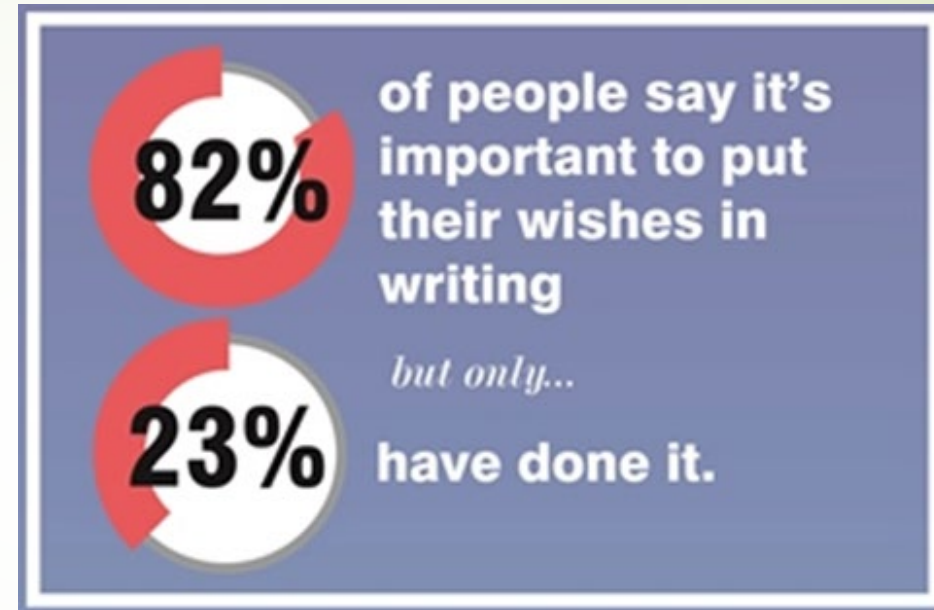
(hardchoices.com) by Hank Dunn



- ➔ Shall resuscitation be attempted?
- ➔ Shall artificial hydration and nutrition be utilized?
- ➔ Should a nursing home resident or someone at home be hospitalized?
- ➔ Is it time to shift the treatment goal from cure to hospice or comfort care only?
- ➔ What outcome can we reasonably expect from medical treatment, given the current medical condition of the patient?

Components of Advanced Directives

- Do Not Resuscitate
 - (No CPR)
- Do Not Intubate
 - (No Ventilators)
- Feeding Tubes
 - Artificial Nutrition
- Artificial Hydration
 - IV's
- Medications
 - When to withdraw routine medications
 - Comfort measures/pain management
- Do Not Hospitalize



Do Not Resuscitate (CPR) & Do Not Intubate (Mechanical Ventilation)

- How successful are efforts to restart a heart?
- Are there any complications?
- Can we know ahead of time which patients are most likely not to be revived by resuscitation efforts?
- How do patients let their wishes be known if they choose not to have resuscitation efforts?

Artificial Nutrition/Artificial Hydration Feeding Tubes/IV's

- ➔ What are some of the benefits of artificial feeding tubes?
- ➔ What are some of the complications of artificial feeding tubes?
- ➔ What are some of the advantages of dying without the use of artificial feeding or IV's?
- ➔ What is a time limited trial?

Cure sometimes, Comfort always

- ➔ When is the “right time” to prepare for dying”
- ➔ What is Hospice?
- ➔ How can I assure that there will be a peaceful death?

Do Not Hospitalize (DNH)

- ▶ What are some of the issues one needs to consider when thinking about hospitalization, ventilator support, dialysis, or the use of antibiotics?
- ▶ How do I communicate my treatment wishes to the medical team caring for me?
- ▶ What are some questions that need to be answered to help me make a decision about life-prolonging procedures?

What options are available to support individuals and their caregivers as medical condition worsen?



Palliative care is about helping people maintain quality of life through practical help, physical care, medicines, and spiritual and emotional support.



Hospice

- Hospice is a philosophy of care for individuals with life-limiting medical conditions which focuses on:
 - Care delivered wherever the individual lives
 - Physical symptom management
 - Emotional support for the individual, as well as their support system, and caregivers
 - Spiritual support for individuals, their support system, and caregivers
 - Bereavement Care



**Our job is not to make up anybody's mind,
but to open minds and to make the agony
of the decision-making less intense**

~Author Unknown