

## Advancing Care Planning – Center Stage in Recent Institute of Medicine Report

**O**n September 17, 2014 the Institute of Medicine’s Committee on Approaching Death – Addressing Key End-of-Life Issues – released their report, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End-of-Life*. In this consensus report from the IOM, a committee of experts found that “improving the quality and availability of medical and social services for patients and their families could not only enhance quality of life through the end of life, but may also contribute to a more sustainable care system.” Not surprisingly, at the top of the list for both key findings and accompanying recommendations was “Clinician-Patient Communication and Advance Care Planning.” The report highlighted the need for professional societies and other organizations to develop standards for clinician-patient communication and advance care planning that are measurable, actionable and evidence based.

The Key findings surrounding advance care planning were:

- Advance care planning is essential to ensure that patients receive care reflecting their values, goals and preferences.
- Of people who indicate end-of-life care preferences, most choose care that is focused on alleviating pain and suffering. Because the default mode of hospital treatment is acute care, advance care planning and medical orders are needed to ensure that preferences are honored.

- Frequent clinician-patient conversations about end-of-life care values, goals and preferences are necessary to avoid unwanted treatment. However, most people do not have these conversations. Clinicians need to initiate these conversations and work to ensure that patient and family decision making is based on adequate information and understanding.

The recommendations for advance care planning encourage:

- All individuals, including children with the capacity to do so, to have the opportunity to participate actively in their health care decision making throughout their lives and as they approach death, and receive medical and related social service consistent with their values, goals and informed preferences;
- Clinicians to initiate high-quality conversations about advance care planning, integrate the results of those conversations into the ongoing care plans of patients, and communicate with other clinicians as requested by the patient; and
- Clinicians to continue to revisit advance care planning discussions with their patients because individuals’ preferences and circumstances may change over time.

To read the full report, go to:

<http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>



# HEALTH DECISIONS

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*The mission of the  
Vermont Ethics Network  
is to promote ethics as  
a core component of  
health care and health care  
decision-making*

Vermont Ethics Network  
61 Elm Street  
Montpelier, VT 05602  
Telephone: 802-828-2909  
Fax: 802-828-2646

Email: [ven@vtethicsnetwork.org](mailto:ven@vtethicsnetwork.org)  
Web site: [www.vtethicsnetwork.org](http://www.vtethicsnetwork.org)

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## VEN FALL ETHICS CONFERENCE

### Advance Care Planning: It's Always Too Soon... Until It's Too Late

Wednesday, October 29, 8:00 AM–4:00 PM  
Lake Morey Resort and Conference Center  
Fairlee, Vermont

Lead Partner – VNA's of Vermont

Registration and information:  
[www.vtethicsnetwork.org](http://www.vtethicsnetwork.org) or (802) 828-2909

In response to the growing need to integrate advance care planning into Vermont's standard of practice, VEN is dedicating the annual fall professional conference to the topic of *Advance Care Planning: It's Always Too Soon... Until It's Too Late*.

### Featured National Speakers

**J. Andrew Billings, MD** is a general internist, specialist in hospice and palliative medicine and the founder and Director of the Palliative Care Service at Massachusetts General Hospital. Dr. Billings is a nationally known educator in end-of-life care. His teaching focuses on end-of-life care and especially on communication issues.

**Susan Block, MD** is a Professor of Psychiatry, Chief of Psychosocial Oncology and Palliative Care at the Dana-Farber Cancer Institute and the Co-Director of the Harvard Medical School Center for Palliative Care. She is a nationally and internationally known researcher and expert in palliative care and psychoncology. She is currently collaborating with Dr. Atul Gawande to create and test a Serious Illness Communication Checklist designed to improve the achievement of patient goals at the end of life.

**Nathan Goldstein, MD** is an Associate Professor in the Brookdale Department of Geriatrics and Adult Development at the Mount Sinai School of Medicine. He is a clinician investigator whose work examines patient-physician communication about deactivating implantable cardioverter-defibrillators. He is currently leading a multi-center intervention to improve patient-physician communication about the management of implantable defibrillators for patients with advanced disease.

### Goals & Objectives

- Understand & appreciate the role of ACP in best practice standards of care within a reforming health care system.
- Develop tools, techniques & communication skills necessary for determining patient goals & discussing the effectiveness of potential treatments.
- Recognize and appreciate common barriers to ACP and develop strategies for overcoming them.
- Understand decision-making capacity, autonomy and voluntariness and its connection to ACP.
- Begin the process for creating necessary systems changes within VT to ensure that ACP is integrated into the system of care delivery

### Agenda

- 8:00 Arrival, Registration & Breakfast  
8:45 Welcome & Conference Goals  
9:00 *Setting the Stage: The Ethical Imperative for Advance Care Planning*, **Robert Macauley, MD**  
9:20 Plenary Session 1: *A Systematic Approach to Personalizing Care: The Serious Illness Care Program*  
**Susan Block, MD**  
10:30 BREAK  
10:50 Plenary Session 2: *Safeguards in Advance Care Planning*  
**J. Andrew Billings, MD**  
12:00 LUNCH (included)  
1:00 Plenary Session 3: *Advance Care Planning for Patients with Heart Failure*, **Nathan Goldstein, MD**  
2:00 Breakout Sessions: Select One  
A. *Decision-Making Capacity, Autonomy and Voluntariness*  
**Sally Bliss, RN, MSB and Peter Mills, PhD, MS**  
B. *Removing Barriers to Advance Care Planning in Primary Care: A practical, patient-centered approach*  
**Zail Berry, MD**  
3:00 BREAK  
3:15 *Improving Vermont's System*  
**Robert Macauley, MD**  
4:00 Evaluations & Pick up CME/CEU's

## Vermont Ethics Network (VEN) Provides Input to Legislative Review of Mental Health Process

During this past legislative session, the Vermont legislature considered revisions to the mental health law in response to delays in processing certain mental health proceedings and to extended stays for some mental patients in Vermont emergency rooms. Whether, when, and how to involuntarily medicate patients suffering from mental illness is a complex and emotionally-charged question. Bob Macauley, Clinical Ethicist at Fletcher Allen Health Care and VEN Executive Director, Cindy Bruzzese, provided testimony concerning overarching medical ethics principals which bear on involuntary treatment and mental capacity determinations. The role of ethical analysis is not so much to specify which side is “right,” but rather to identify the ethical underpinnings of competing views. VEN was provided with a unique opportunity to include consideration of bioethical principals into the policy-making process.

Issues of involuntary commitment and treatment raise important values of personal autonomy and patients’ rights. In January of 2014 it was reported to the Legislature that hospital staff involved in involuntary medication wanted the process leading to involuntary medication to move as quickly as possible, while continuing to protect patients’ rights. Patient peer representatives and some Legal Aid lawyers argued that applications for involuntary, non-emergency court-ordered medication were filed too quickly and used more frequently than in past years.<sup>1</sup>

The outcome of Vermont’s review of the mental health law was the passage of S-287 which has since been enacted into law as Act 192. The legislature chose to address three basic problems with the prior mental health process: (1) the fact that Vermont hospital emergency rooms had become

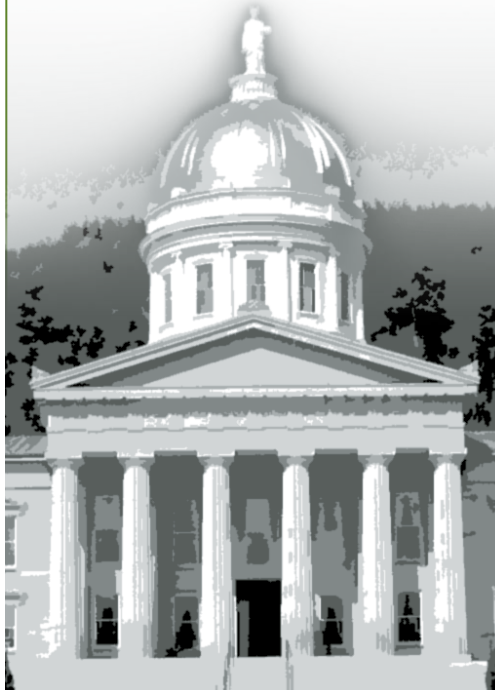
the entry point, and sometimes the holding place, for patients entering the mental health system; (2) the questionable legal status of mental patients being held in hospital emergency rooms; and (3) the delay in filing, hearing and enforcement of involuntary medication orders.

Under prior law, a person who was subject to an application for emergency examination toward commitment would be admitted to a “designated hospital”<sup>2</sup> for emergency examination by a psychiatrist. (In past times this was usually the Vermont State Hospital in Waterbury.) The new law changed the process for emergency examination in that the patient is to “be held for admission to a hospital.”<sup>3</sup> The “designated hospital” language was amended to be simply a “hospital”. According to Madeleine Mongan, “Acknowledging the reality of the decentralized mental health acute care system in Vermont, S. 287 requires the legal commitment process to start when a patient is held in an emergency department prior to admission...”<sup>4</sup>

Once a person is held in the hospital for emergency examination, a “second certification” by a psychiatrist must take place not later than 24 hours after the initial certification.<sup>5</sup> If the second certification is not issued the patient should be released or discharged. If the second certification is issued, then the patient may be held for an additional 72 hours. The patient may continue to be held thereafter if he or she voluntarily admits to the hospital, or if an application for involuntary treatment is filed with the appropriate court. The ability of the second certification to be completed by a psychiatrist within the 24 hour deadline may be a challenge in some of the remote parts of the state.

The legal status of the patient is also resolved under the new law. The patient is under the “temporary custody” of the Commissioner of Mental Health from the point of the physician filing the initial certification until the point of discharge or until the court acts upon the application for involuntary treatment.<sup>6</sup> Thus, it is the Commissioner of Mental Health who is responsible for the patient who is being held in the emergency room for emergency examination.

In addition to the above processes, the Legislature added a “probable cause review” of each application for involuntary treatment to be conducted without a hearing. The Superior Court judge reviews the application for emergency examination, the physician’s certificate, and the application for involuntary treatment to determine if there was probable cause to believe that the patient was a person in need of treatment at the time of admission to the hospital.<sup>7</sup> This review must be done within 3 days from the filing of the application for involuntary treatment; breach of the 3-day deadline will not cause a dismissal if there is good cause for delay. This new



process is in addition to the existing right of the patient under Vermont law to request a preliminary review hearing after five days of admission for emergency examination. Such hearings, if requested by the patient, must be heard within 3 days of filing the request.<sup>8</sup>

The legislature also added a process where either the petitioner or the patient may move for an expedited hearing on applications for involuntary treatment. If the motion is granted, the hearing will be held within 10 days of the date the motion is granted.<sup>9</sup>

Under prior law, petitions for involuntary medication could only be filed after the patient was placed in the care and custody of the Commissioner by an order of involuntary treatment. Also, such orders of involuntary medication were subject to an automatic stay for thirty days in case the patient might appeal the involuntary medication order. These two provisions made many involuntary medication orders untimely. The new law allows petitions for involuntary medication to be filed when the application for involuntary treatment has been ordered to be expedited,<sup>10</sup> or, when the application has been pending for more than 26 days and the treating psychiatrist certifies that additional time will not result in the establishment of a therapeutic relationship with providers or regaining competence, and serious deterioration of the person's mental condition is occurring. The Court may consolidate the hearing of the application for involuntary treatment with the petition for involuntary medication in these two instances. The automatic stay of involuntary medication orders is no longer automatic, but may be granted by the trial court upon the appellant filing a motion for stay where an appeal has been filed.<sup>11</sup>

The new provisions of Act 192 provide additional legal protections to persons held in Vermont emergency rooms and allow for expedited processes in certain cases.

– GEORGE BELCHER

- 1 Flint Springs, *An Independent Study of the Administration of Involuntary Non-Emergency Medications Under Act 114*, pp. 1 & 2, <http://www.leg.state.vt.us/reports/2014ExternalReports/295581.pdf>
- 2 18 VSA Sec. 7504(a). A “designated hospital” is a hospital or other facility designated by the Commissioner of Mental Health as adequate to provide appropriate care for the mentally ill patient. 18 VSA Sec. 7101(4)
- 3 18 VSA Sec. 7504. An application for emergency examination is accompanied by a certificate of a licensed physician stating that the patient is a person in need of treatment (i.e. mentally ill and a danger to self or others).
- 4 Vermont Medical Society Legislative Bulletin, 2014. Madeleine Mongan is the Deputy Executive Vice President of the Vermont Medical Society.
- 5 18 VSA Sec. 7508(a)
- 6 18 VSA Sec. 7508(e); “temporary custody is not defined but “custody” is defined as “safe-keeping, protection, charge or care” 18 VSA Sec. 7101(3)
- 7 18 VSA Sec. 7612a
- 8 18 VSA Sec. 7510
- 9 18 VSA Sec. 7615(a)(2)(B)
- 10 18 VSA Sec. 7624(a)(4)
- 11 Act 192, Sec. 22, re VRCP Rule 12(d)

## Vermont Passes New Law Relating to Consent for Admission to Hospice – Act 127

**O**n May 10, 2014 Governor Shumlin signed a new law to address the question of what a Hospice program should do when a patient is no longer capable of giving consent for admission to hospice care and they do not have an agent or guardian who can do so on their behalf. With no surrogacy statute in Vermont it had been unclear how Hospice programs should handle this situation. Now, with the passage of Act 127 (H.874) a family member of a patient or a person with a known close relationship to the patient may elect hospice care on behalf of the patient if the patient does not have an agent or guardian or the patient's agent or guardian or both are unavailable. Decisions made by the family member or person with a known close relationship to the patient shall protect the patient's wishes in the same manner as is described for health care agents in the advance directive statute.

To read Act 127 in its entirety go to: <http://www.leg.state.vt.us/docs/2014/Bills/H-0874/ACT0127%20As%20Enacted.pdf>.

## Health Care Planning is for Everyone

*It's always too soon...until it's too late –  
Start the Conversation Today!*

- TALK to others about your values and future health care wishes.
- GO to [www.vtethicsnetwork.org](http://www.vtethicsnetwork.org) for the Vermont Advance Directive Form and for comprehensive information about Advance Care Planning and Advance Directives.
- COMPLETE your Advance Directive.
- REGISTER your Advance Directive with the Vermont Advance Directive Registry—an easy and secure way to give your health care providers immediate access to your wishes about health care decisions.

For more information about the Vermont Ethics Network, or to order the Taking Steps Booklet, contact us by phone at 802.828.2909 or via e-mail at [ven@vtethicsnetwork.org](mailto:ven@vtethicsnetwork.org).

## Vermont Ethics Network Welcomes New Board Members

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**Sally Bliss, RN, MSB:** Sally is a Clinical Ethicist at Fletcher Allen Health Care in Burlington Vermont and the incoming Chair of the Vermont Ethics Network Board of Directors. She is also an Adjunct Assistant Professor of Medicine, and the Student Ombudsperson at the University Of Vermont College Of Medicine. She began her career in nursing after earning a B.S. in Physiology from Syracuse University and an A.S. in Nursing from Norwich University. After serving for many years at the bedside in surgical intensive care, and as a clinical supervisor and administrator, she began to study the field of bioethics in order to better understand and address the complex decisions encountered in the delivery health care. Sally earned her M.S. in Bioethics from the Union Graduate College/Mt. Sinai College of Medicine Program in Bioethics, and served as an Assistant Professor of Clinical Ethics in the program for 4 years before returning home to her native Vermont and Fletcher Allen in 2009. In addition to her primary roles, she is a member of the American Society for Bioethics and Humanities, and Co-chairs the Rural Ethics Affinity Group.

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**Danielle De Longis, LICSW:** Danielle is currently a clinical coordinator at BCBS of VT. She provides mental health and substance authorization for treatment and case management to members and providers. She is also an adjunct professor at Johnson State College where she has taught ethics in the graduate counseling department for the past 12 years. Previously, she worked in an elementary school practicing social work with a primary responsibility providing psychotherapy to children and families. She also has experience providing social work services to Vermonters through a designated community mental health agency. She has experience as a Military Family Life Consultant providing short term nonmedical counseling to VT Army/Air National Guard and Navy Reserve service members and their families. Danielle has her Master in Social Work from Smith College in Northampton, MA.

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**Peg Maffitt:** Peg joins the VEN Board as a community member with a long time passion and interest in end-of-life care issues. She brings leadership experience in numerous non-profit organizations dealing with hospice and palliative care. At present, she is a key member and point-person for the Madison-Deane Initiative, the educational arm of the VNA's End-of-Life Care Services for Chittenden and Grand Isle Counties. Prior to joining the VEN Board, Peg had chaired the MDI for seven years, was a long time hospice volunteer and a founding board member of The Vermont Respite house. She was the moving force behind raising the funds to acquire and house the first ambulance in Shelburne VT. In her professional life, she was the Capital Campaign and Development director of the King Street Center in Burlington for over twelve years. She currently resides in Burlington with her husband, Tom.

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**Peter Mills Ph.D., M.S.:** Peter has worked as a Psychologist in the VA in White River Junction VT since 1994. He is currently the Director of the VA National Center for Patient Safety Field Office. He joined the National Center for Patient Safety in 2002 and has focused on suicide prevention, patient safety improvement and measuring patient safety in VA. Prior to joining the NCPS he was the Associate Director of the VISN 1 Patient Safety Center of Inquiry and directed several national medical safety improvement projects within the VA system. From 1994 to 1999 he served as the director of the Evaluation and Brief Treatment of PTSD Unit, and the Director of the PTSD service. He is Adjunct Associate Professor of Psychiatry in the Geisel School of Medicine at Dartmouth. He conducts research in patient safety, dissemination of medical innovation and the characteristics of medical improvement teams.

He has served as the Chair of the Clinical Ethics Committee at the VAMC in White River Junction and a member (ex-officio) of the Bioethics Committee, Dartmouth Hitchcock Medical Center since 2002; and the Chair of the Integrated Ethics committee at the VAMC since 2005.

He lives in Norwich Vermont with his wife Jan and two sons (current in college).



# VERMONT ETHICS NETWORK

— Advancing —  
Health Care Ethics

61 Elm Street  
Montpelier, VT 05602

Phone: 802-828-2909  
Fax: 802-828-2646

Visit us online at  
[www.vtethicsnetwork.org](http://www.vtethicsnetwork.org)

## VEN NEWS & UPDATES

### NEW! ADVANCE DIRECTIVE FORM FOR APPOINTING A HEALTH CARE AGENT

Vermont Ethics Network is pleased to announce a newly designed form to help Vermonter’s take their “First Step” in the advance care planning process by appointing a health care agent. Accidents and sudden illness can happen to anyone at any time. Selecting in advance a person whom you trust who can speak on your behalf is a necessary first step for all adults with decision-making capacity. This two-page form is now available on the VEN website at [www.vtethicsnetwork.org](http://www.vtethicsnetwork.org). Start the planning process today!

### FALL ETHICS CONFERENCE

#### ADVANCE CARE PLANNING: IT’S ALWAYS TOO SOON... UNTIL IT’S TOO LATE

Wednesday, October 29, 8 AM–4 PM  
Lake Morey Resort and Conference Center,  
Fairlee, Vermont

Registration and detailed information about this event can be found at [www.vtethicsnetwork.org](http://www.vtethicsnetwork.org) or by calling (802) 828-2909. (See page 2 for details.)

**APPOINTMENT OF A HEALTH CARE AGENT**  
*Vermont Advance Directive for Health Care Decisions*

YOUR NAME ..... DATE OF BIRTH ..... DATE .....

ADDRESS .....

CITY ..... STATE ..... ZIP .....

Your **health care agent** can make health care decisions for you when you are unable or unwilling to make decisions for yourself. You should pick someone that you trust, who understands your wishes and agrees to act as your agent. Your health care provider may NOT be your agent unless they are a relative. Your agent may NOT be the owner, operator, employee or contractor of a residential care facility, health care facility or correctional facility where you reside at the time your advance directive is completed.

I appoint this person to be my health care AGENT:

NAME .....

ADDRESS .....

HOME PHONE ..... WORK PHONE .....

CELL PHONE ..... EMAIL .....

(If you appoint co-agents, list them above or on a separate sheet of paper)

If this agent is unavailable, unwilling or unable to act as my agent, I appoint this person as my **alternate agent**:

NAME .....

ADDRESS .....

HOME PHONE ..... WORK PHONE .....

CELL PHONE ..... EMAIL .....

Others who may be consulted about medical decisions on my behalf include:

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Primary care provider (Physician, PA or Nurse Practitioner):

NAME ..... PHONE .....

ADDRESS .....

NAME ..... PHONE .....

ADDRESS .....

Those who should NOT be consulted include:

.....

6/14

Doctor, Provider(s) .....

Hospital(s).....

Family Member(s): please include a separate sheet of paper if you need more room .....