


**A Brief Orientation:
Advance Care Planning
With Mental Health in Mind**

Presented by:

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Behavioral Health Peer Pilot Program – Winter, 2021
Advance Care Planning/Supportive Care Integration Program
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www.CaringCommunity.org

Remember: This is only 15 minutes total – a brief orientation. Stay focused!
Change Presented by: to your name if not Susan is not doing.

Each Slide: Begin with Speaker Notes provided to guide slide review.

Introduce self.

Program attendees should be provided with and review these handouts:

An Overview: Advance Care Planning Cornerstones (2 page)

Table of Contents - Making A Plan Toolkit with Website to access Toolkit (1 page)

Tech Notes:

- Show only the slide, not the speaker notes, print out before presenting
- Consider showing in “Reading View” located in “View” toolbar. No clutter!
- Use key board arrows to advance thru slides


**Briefing Overview**


- Talk about the importance of advance care planning (ACP)
- Review the ACP process and elements essential for success
- Provide insight into ACP with Mental Health in Mind
- Introduce Making A Plan Thinking Ahead Toolkit
- Note how to learn more


This is a brief overview to encourage you to learn more and take steps needed to help an individual living with mental health challenges do advance care planning. That will enable the individual to make their treatment wishes known and honored in a crisis when they are unable to guide their own care.


Speaker Note: May need to adjust pronoun reference depending on the audience.

Behavioral Health Peer Pilot Program Roots









Peer Centers Leadership assisting included:

Interlink Self-Help Center; The Wellness & Advocacy Center;
Russian River Empowerment Center; Petaluma Peer Recovery Center.

Before we begin, I'd like to tell you a little about the roots of this program. It grew out of a collaborative effort between (above) at a time when Goodwill operated the Peer Support Centers serving Sonoma County.

The need for this program was determined by clinicians with the Older Adult Team of BH who found there were no appropriate advance care planning resources helpful for people living with mental health challenges.

This program addressed that need by creating the new tools and training that we will be talking about today.

Peers Centers that participating in creation of these materials , this orientation production and overall project development include those listed on slide.

Speaker Note-Don't include with presentation. FYI Only. Serious mental health challenges is a term used by the behavioral health division to describe clients served. To clinicians, this is an important distinction and appropriate to use when speaking with clinicians. HOWEVER, when speaking to people living with mental health challenges, we do not differentiate and therefore do not use that term "serious" with peer audiences. To peers, diagnosis is not the focus.

Hope is Not A Plan



**When the plan is unclear,
the default is to treat aggressively.**

As we think about advance care planning, it's important to recognize that HOPE is Not A Plan.

Aggressive treatment is the default when there is no advance care plan in place or no one to legally speak on behalf of the individual.

Health care professionals are trained to do all possible in a health care crisis when a person is unable to make their wishes known.

Why Advance Care Planning (ACP) Is Important

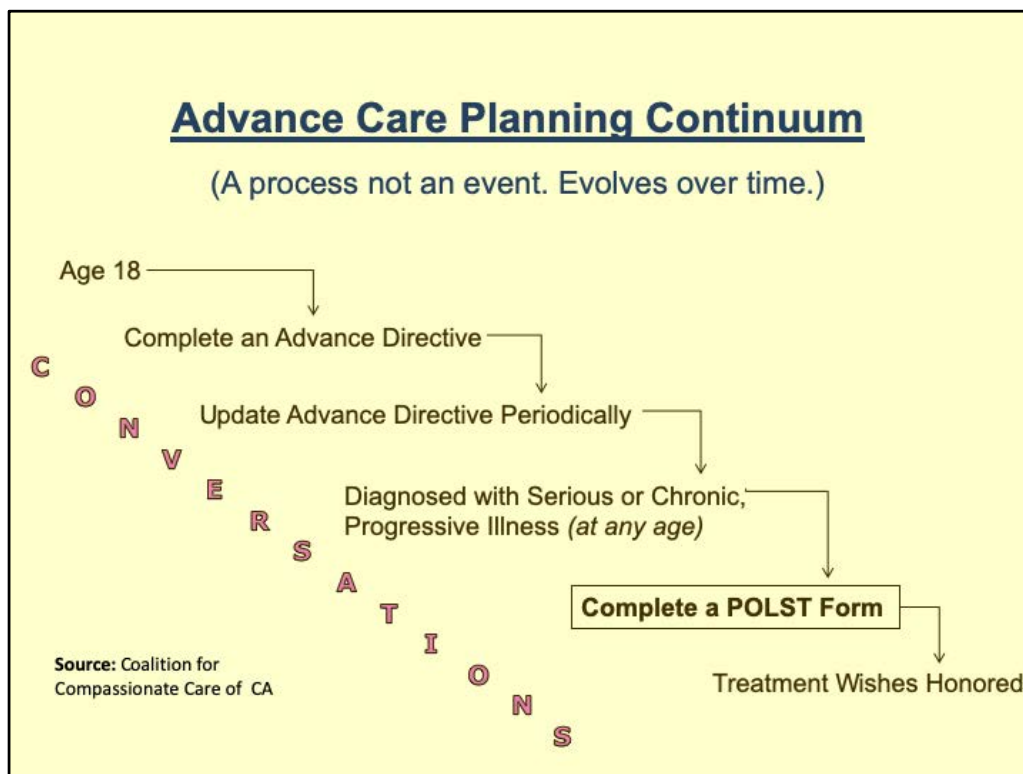
- Prepare for difficult decisions ahead of the crisis
- Give instructions for care that reflect a person's goals, wishes, values, beliefs and medical reality
- Ensure a match between patient goals and the medical treatment provided
- Facilitate communicating choices to those who need to know (e.g., trusted advocates, healthcare agents, family, physician, other healthcare providers, spiritual advisors).

Conversations are key!

Advance care planning helps us to get the care we want, when it's needed in the place of our choosing whenever possible. Advance Care Planning is important because it helps us:

Do bullets. . .

And in it all . . . Conversations are key!



The Advance Care Planning Continuum:

- Starts at age 18 with completing an Advance Health Care Directive.
- The AHCD is updated periodically to stay current.
- At any age, when diagnosed with a serious or chronic, progressive illness, the Physician Order for Life Sustaining Treatment or POLST form comes into the mix.
- The goal is that an individual's treatment wishes are known and honored.

Notice the word along the left side: **Conversations**.

- Ongoing conversations over the years with the individual's healthcare decisionmaker, family, and healthcare provider are very important and necessary to make this all work.

We'll talk more about POLST shortly.

What's An Advance Health Care Directive?

The Advance Directive is a **legal document** that:

- Has an individual's choices about care desired when seriously ill, incapacitated or at life's end.
- Can include choices about mental health care desired.
- Says who an individual wants to speak with their doctor and other health care providers if they cannot speak for them self.
- Helps guides the individual's doctor and others about what kind of care the individual wants.
- Gives their Health Care Agent/Surrogate legal standing.
- Protects the healthcare provider from liability when following the patient's wishes as expressed in the AD.

So what is an AHCD you may wonder. It is a legal document used to appoint a health care agent(s) and generally specify what health care **including mental health care should be provided if an individual is unable or unwilling to make decisions for themselves because of illness or incapacity.**

The AHCD legally assigns authority to a health care agent/surrogate to make medical decisions and guide care when an individual is unable. If no agent/surrogate is designated, the AHCD helps guide healthcare professionals responsible for providing care when an individual is unable to guide their care.

From a liability standpoint, the healthcare organization has more protection if they follow the patient's wishes (as expressed in the advance directive and by the surrogate) than if they don't. Not following the patient's wishes could open up the organization to liability for battery or negligence. (Judy Thomas, JD, CEO, CCCC 2/19)

Who Can Complete an AHCD?

- Anyone 18 years or older.
- California law presumes capacity for patients and their surrogates.
- Conserved people are presumed to have capacity unless it is determined otherwise.

Capacity means that the person has the ability to understand what is being said or done including the risks and benefits, and can make their own decisions.

California law provides that any person 18 years and older is presumed to have capacity to make an Advance Directive. The law presumes that patients (and their surrogates) have capacity. The fact that a patient (or surrogate) is going against medical advice or making a ‘bad decision’ does not indicate lack of capacity to make medical decisions.

Capacity means . . . Read from slide above re capacity means. . . .

For Reference Only. Don’t present given time limitation.

Lanterman-Petris-Short (LPS) conserved persons are not considered incompetent by reason of conservatorship. If you are on a LPS conservatorship you retain the right to make treatment decisions and to complete an Advance Directive unless there is a determination that you lacked capacity at the time you made treatment decisions and completed your Advance Directive.

Reference: Disability Rights CA (DRC) AHCD for Mental Health-A Trainer’s Manual, “Problem Solving” Item h including footnotes, page 29. DRC is California’s Protection and Advocacy System. For free DRC legal assistance call 1-800-776-5746. www.disabilityrightsca.org. And Judy Thomas, JD, CEO, CCCC 2/14/19

What is the Role of POLST in ACP?

Physician Orders for Life-Sustaining Treatment



- **POLST is a legally binding portable care plan** that allows healthcare providers to know and honor patient wishes during serious illness **in terms of intensity of medical treatment desired** re: DNR/CPR; Comfort Care, Full Treatment or Selective Interventions.
- POLST is primarily used to help give **seriously ill patients** more control over their treatment.
- The AHCD **is not** a Physician Order. The AHCD is a statement of values, wishes and preferences requiring interpretation. **POLST complements the AHCD.**
- The AHCD is addressing future care wishes. POLST is addressing immediate needs given current conditions.

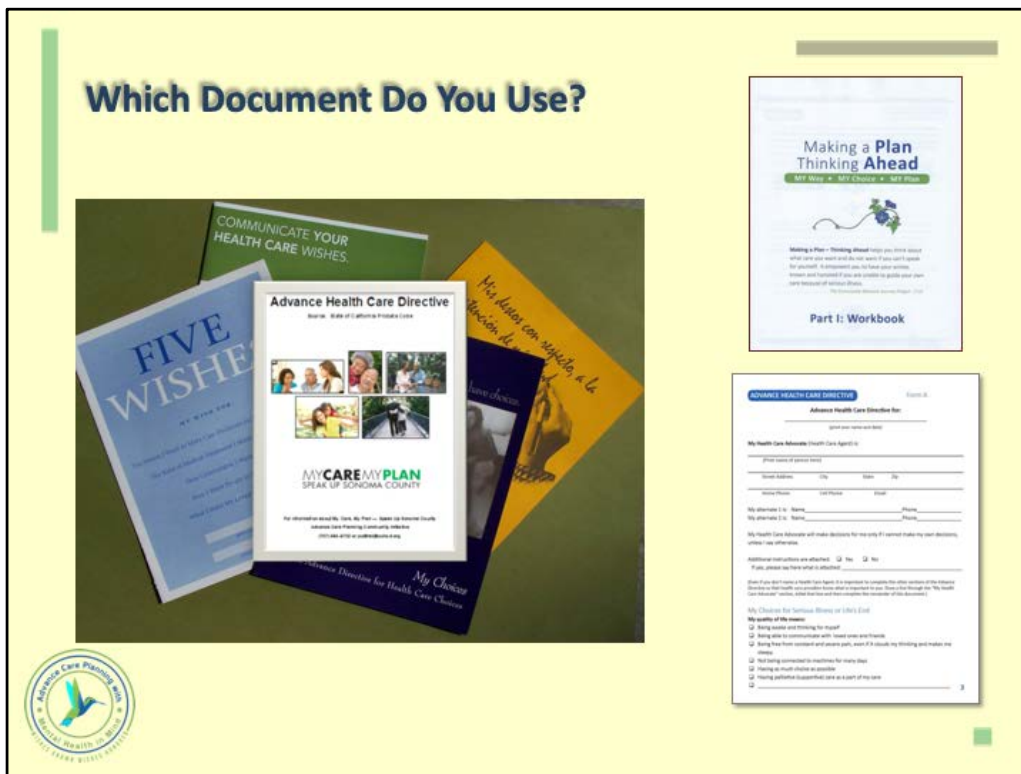
Speaker Note: Present this slide as is in slide. Brief!

Include comment: We don't go in depth about POLST in this program but do want you to know what it is and how it works.

This below Reference Only if needed and time allows.

POLST stands for Physician Orders for Life-Sustaining Treatment.

- It is a physician order that is recognized throughout the medical system.
- It clearly states what level of medical treatment a patient wants toward the end of life.
- It is a portable document that transfers with the patient from one care setting to another.
- It is easily distinguished by its bright pink color.
- It is a standardized form for the whole state.
- POLST helps give seriously-ill patients more control over their treatment.


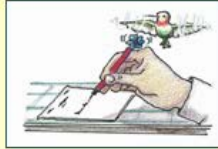



California law is very flexible about which AHCD form an individual can use . . . And there are many choices.

Some forms are more user friendly than others. Some forms are more legal and technology focused while others are more focused on personal values.

As I said in the beginning of this program, the Peer Pilot Program created new forms to better assist those we serve living with mental health challenges.

The Making A Plan Toolkit we will review briefly today, was created with the help of mental health peers to address special needs of the peer population and those who are of service. This focus is what makes our documents unique among them all.

<p><u>Making A Plan Thinking Ahead</u> My Way • My Choice • MY Plan</p> 		<p><u>Advance Care Planning with Mental Health in Mind</u></p> 
<p><u>Table of Contents</u></p> <p><u>Part I: Workbook</u></p> <p>Making Your Decisions Page 5</p> <p>A. Choosing the Right Person to Help Page 5</p> <p>B. Personal Requests about My Care Page 6</p> <p>C. Making Medical Treatment Choices Page 9</p> <p>D. Choosing a Health Care Agent Page 11</p> <p>E. Tips, Resources & Background Page 15+</p> <p><u>Part II: Forms</u></p> <p>A. Advance Directive</p> <p>B. Personal Requests </p> <p> 1) Care Wishes</p> <p> 2) Personal Belongings</p> <p>+ <u>Mental Health Supportive Care Plan</u></p> <p> • With Checklists</p> <p> • With Open Ended Questions</p> <p><small>Prepared by Susan Keller, Community Network Journey Project 7/23/20 CaringCommunity.org</small></p>		
		<p>In-depth 1 hour class on MAP Toolkit soon available. To get on class wait list email: skeller@pacific.net. Please Include note you did today's program.</p> <p>Forms available at CaringCommunity.org</p>

To end this briefing, I will do a quick review of what's in the Making A Plan Toolkit and invite you to attend a one hour program to learn more.

For now, by way of introduction to the MAP Toolkit, let take a quick look at the table of contents which you received as a handout along with the Overview of ACP Cornerstones.

(Review quickly what's in there noting this all can help an individual to get their documents completed. Note how pieces interconnect e.g. having the Mental Health Supportive Care Plan be done as an attachment to the AHCD to give it legal standing. Also note that we encourage people to do this with a Trusted Helper.

We'd like to invite you to attend a one-hour follow up program that will walk through these materials to help you better understand what's here and how to get it working for someone you know and/or care for who could benefit from doing advance care planning.



If you would like to get the Making A Plan Toolkit or have a look at this all more in depth please do visit our website. The Home Page will guide you to “ACP with Mental Health in Mind” tools and resources.

Or better yet, plan to attend the one hour Orientation program where we look at all of this more in depth.

Thank you for attending.

We’ll take a few minutes for questions or comments before we end.