Thoughtful Life Conversations

Advance Care Planning

for U of A Faculty

July 13, 2022

AzHHA participates in the Arizona End of Life Care Partnership, which is supported by The David and Lura Lovell Foundation and the Community Foundation for Southern Arizona.

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Our Objectives

1. Describe the importance of Advance Care Planning for patients and families across the lifespan
2. Review the common Advance Care Planning forms, including Living Will, Durable Medical Power of Attorney, and POLST
3. Explain how to use the Arizona Healthcare Directives Registry (AZHDR)
4. Demonstrate communication strategies to engage patients in a conversation about advance care planning across the continuum of care (e.g., health fair, ambulatory setting)
5. Recognize the role of Public Health professionals as part of an interprofessional team in the care of patients with serious illness and life-limiting illness
6. Describe the role of community resources and services in promoting advance care planning for patients and families across the lifespan

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Who Needs to Have the Conversation?

the conversation project

View the above video here:

https://www.youtube.com/watch?v=sp6pSA4ZiLY&feature=youtu.be

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The Challenge We Face

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Approximately one in three US adults completes any type of advance directive for end- of-life care.[1]

39% of Arizonans report they have completed an advance directive. [2]

[1]Yadav, Kuldeep N., Nicole B. Gabler, Elizabeth Cooney, Saida Kent, Jennifer Kim, Nicole Herbst, Adjoa Mante, Scott D. Halpern, and Katherine R. Courtright. "Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care." *Health Affairs* 36.7 (2017): 1244-251. Web. 12 July 2017.

[2]*Arizona Statewide Survey by Public Opinion Survey, August 2018*

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Barriers to Discussing EOL Wishes

National

- Too Many Other Things to Worry About Right Now
- Don't Want to Think About Dying
- Loved One Does Not Want to Talk About Death or Dying
- Too Young/Long Way Off
- Haven't Thought About It
- No One to Talk To
- Will trust my healthcare team to make decisions

Arizona

- Haven't gotten around to it (41%)
- Never considered it (22%)
- I'm healthy; I'm young; Don't think it is necessary (20%)

Arizona Statewide Survey by Public Opinion Survey, August 2018

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Why and How To Begin Planning

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Why Plan for End of Life?

50% of people become incapacitated and thus unable to make their own medical decisions.

The Default is to treat aggressively, even if this is not desired, and even if it is hard for the family to predict the patient's wishes.

Source: Gundersen Lutheran Medical Foundation, 2002

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Start with Personal Reflection

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Personal Reflection

Check all answers that apply

1. Who died in your first personal experience with death?

- ❑ Grandparent/great-grandparent
- ❑ Parent
- ❑ Brother or sister
- ❑ A child
- ❑ Other family member
- ❑ Friend or acquaintance
- ❑ Stranger or a public figure
- ❑ Animal or pet

2. When you were a child, how was death or dying talked about in your family?

- ❑ Openly
- ❑ With some sense of discomfort
- ❑ As though it were a taboo subject
- ❑ Do not recall any discussion

3. What does death mean to you?

- ❑ The end; the final process of life
- ❑ The beginning of a life after death; a transition, a new beginning
- ❑ A kind of endless sleep; rest and peace
- ❑ End of this life, but survival of the spirit
- ❑ Other (specify):

4. What about your own death concerns you most?

- ❑ I could no longer have any experiences.
- ❑ I am afraid of what might happen to my body after death.
- ❑ I am uncertain about what might happen to me if there is a life after death.
- ❑ I could no longer provide for my family.
- ❑ It would cause grief to my family and friends.
- ❑ There would be some things left undone.
- ❑ I have no concerns about my death.
- ❑ Other (specify):

_____

5. What about the process of dying concerns you most?

- ❑ It would be long and painful.
- ❑ Being a financial burden to my family
- ❑ Causing my family to suffer
- ❑ Being dependent on others to care for me
- ❑ Losing control of my mind and body
- ❑ I am not concerned about the process of dying.
- ❑ Other (specify):

Conversation Tool: Go Wish

- Briefly ready cards & separate into 3 piles:
  - Very important to me
  - Somewhat important
  - Not important
- Wild card to be used for anything
- Identify top 10
- Rank top 10
- Think about talking to your family & loved ones
- Make time to tell them

Play online at:
http://www.gowish.org/gowish/gowish.html

Advance Care Planning Conversations

View the above video here:
https://youtu.be/SF4DORv_UYk

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The Conversation

View the above video here:
https://www.youtube.com/watch?v=pyMXtVprN74

The Conversation Project Starter Kit

Mark all that apply

Who Do You Want To Talk To?

- ❑ Mom
- ❑ Dad
- ❑ Child/Children
- ❑ Partner/Spouse
- ❑ Sister/Brother
- ❑ Faith Leader (Minister, Priest, Rabbi, etc.)
- ❑ Friend
- ❑ Doctor
- ❑ Caregiver
- ❑ Other

When Would Be A Good Time To Talk?

- ❑ The next holiday
- ❑ Before my child goes to college
- ❑ Before my next trip
- ❑ Before I get sick again
- ❑ Before the baby arrives
- ❑ The next time I visit my parents/adult children
- ❑ At the next family gathering
- ❑ Other

Starter Kits. (2017, July 31). Retrieved August 10, 2017, from http://theconversationproject.org/starter-kits/

The Institute for Healthcare Improvement

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Conversation Starters

"I know this is difficult, but I would like to talk to you about something that is really important to me."

"I care about you and want to tell you some things that I hope would make it easier for you if I couldn't make decisions for myself."

"It's OK if you feel uncomfortable with this topic but, please, just listen to me right now."

"I need to think about the future, will you help me?"

"Please, do this for me."

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RESPONSES TO CHALLENGING QUESTIONS		

God's going to bring me a miracle:
• I hope that for you, too. (**Remember: no buts**!) (**SUPPORTING**)
• I really admire and respect. your faith (**RESPECTING**)
• Having faith is very important. (**RESPECTING**)
• Can you share with me what a miracle might look like for you? (**EXPLORING**)
	How much time do I have left?
	
	NOTE: This question may mean many things – they are scared, they want to know so they can plan, they are suffering, etc. Exploring what they want to know can be very helpful.
	
	• That is a great question. I am going to answer it the best that I can. Can you tell me what you are worried about? **(EXPLORING)**
	• That is a great question. I am going to answer it the best that I can. Can you tell me what information would be most helpful to you? **(EXPLORING)**
		Are you saying there is nothing more you can do?
		• I can't even imagine how (**NAME EMOTION**) this must be. (**NAMING)**
		• It sounds like you might be feeling … (**NAMING/EXPLORING)**
		  ○ Alone
		  ○ Scared
		  ○ Frustrated
		  ○ Etc.
		• I wish we had a treatment that would cure you. Our team is here to help you through this. (**SUPPORTING)**

Are you telling me my dad is dying?
 	
NOTE: These responses will affirm the question empathically – so do not use them if the patient is not dying.
• I wish I had better news.
• This must be such a shock for you. (**NAMING**)
• I can't even imagine how difficult this must be. (**UNDERSTANDING**)
	Are you giving up on me?
	• I wish we had more curative treatments to offer. Our team is committed to help you in every way we can. (**SUPPORTING**)
	• We will be here for you. (**SUPPORTING**)
	• It sounds like you might be feeling … (**NAMING/EXPLORING)**
	  ○ Alone
	  ○ Scared
	  ○ Etc.
	• We will work hard to get you the support that you need. (**SUPPORTING**)
		My dad is a fighter!
		
		• He is. He is such a strong person and he has been through so much. (**RESPECTING**)
		• I admire that about him. (**RESPECTING**)
		• I really admire how much you care about your dad. (**RESPECTING**)
		• It must be (**NAME EMOTION**) to see him so sick. (**NAMING**)
		• Tell me more about your dad and what matters most to him. (**EXPLORING**)

WISH (HOPE) / WORRY / WONDER

I'm going to beat this/I'm going to live for many years/I think you're wrong……

I **HOPE** you are right (**validate** patient concerns, goals,) but I am…….
WORRIED because you are having more pain/losing weight/sleeping more (express **empathy/concern**) so……
I **WONDER** whether we should make a plan in case things don't go as well as we would like? (**reframe/plan**)

***Note: These phrases are examples of empathic continuers. Patients may not immediately respond to your first empathic statement. They will often need multiple successive empathic responses to their questions to work through an emotion. ***

Goals of Care Conversations training materials were developed and made available for public use through U.S. Department of Veterans Affairs contracts with VitalTalk [Orders VA777-14-P-0400 and VA777-16-C-0015].

EMPATHIC RESPONSES					
	Understanding	**Respecting**	**Supporting**	**Exploring**	**"I Wish"**
This must be… • Frustrating • Overwhelming • Scary • Difficult • Challenging • Hard	What you just said really helps me understand the situation better.	I really admire your • Faith • Strength • Commitment to your family • Thoughtfulness • Love for your family	We will do our very best to make sure you have what you need.	Could you say more about what you mean when you say… • I don't want to give up • I am hoping for a miracle	I wish we had a treatment that would cure you (make your illness go away). *[Remember we do have palliative treatments to offer the patient]
I'm wondering if you are feeling … • Sad • Scared • Frustrated • Overwhelmed • Anxious • Nervous • Angry	This really helps me better understand what you are thinking.	You (or your dad, mom, child, spouse) are/is such a strong person and have/has been through so much.	Our team is here to help you with this.	Help me understand more about…..	I wish I had better news.
It sounds like you may be feeling …	I can see how dealing with this might be … • hard on you • frustrating • challenging • scary	I can really see how (strong, dedicated, loving, caring, etc.) you are.	We will work hard to get you the support that you need.	Tell me more…	I wish the situation were different.
In this situation some people might feel …	I can see how important this is to you.	You are such a (strong, caring, dedicated) person.	We are committed to help you in any way we can.	Tell me more about what [a miracle, fighting, not giving up, etc.] might look like for you?	I wish that for you too. [In response to what a patient or family members wishes, such as a miracle]
I can't even imagine how (**NAME EMOTION**) this must be.	Dealing with this illness has been such a big part of your life and taken so much energy.	I'm really impressed by all that you've done to manage your illness (help your loved one deal with their illness).	We will go be here for you.	Can you say more about that?	I wish we weren't in this spot right now.

Documenting Your Wishes

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Why Create a Healthcare Directive?

This is a way to make your health care wishes known if you are unable to communicate when the time comes.

It allows a person to do either or both of the following:

- Appoint a decision-maker, a healthcare representative.
- State your instructions for future health care decisions.

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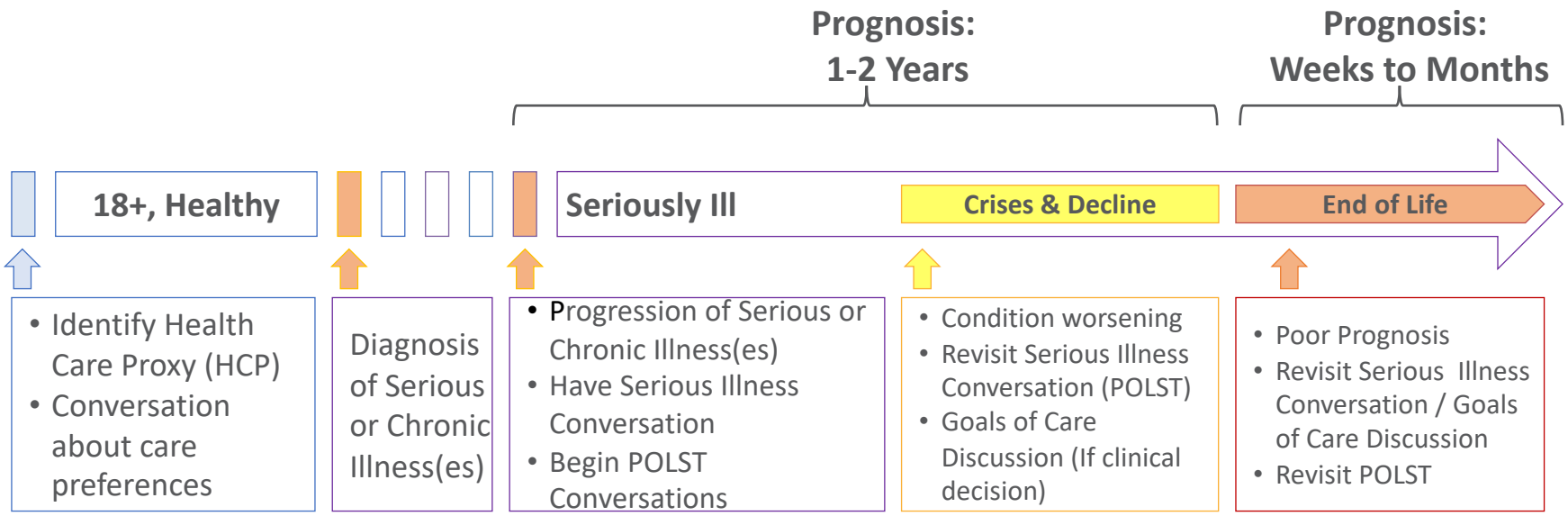
Advance Care Planning Process



Advance Directives

- Planning for future care

Arizona POLST

Serious Illness Care Program, Ariadne Labs

Arizona State Documents

- Living Will
- Healthcare Power of Attorney
- Mental Healthcare Power of Attorney
- Prehospital Medical Care Directive

  (DNR= Do Not Resuscitate)
- POLST

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Advance Care Planning Documents
Many Options Available

Arizona Advance Health Care Directive

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

Part 1 **Choose a medical decision maker, Page 3**

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself.

They are also called a health care agent, proxy, or surrogate.

Part 2 **Make your own health care choices, Page 6**

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 3 **Sign the form, Page 11**

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out only the parts you want. Always sign the form in Part 3.

1 witness needs to sign on Page 12, or a notary on Page 13.

Your Name

Developed by PREPARE for your care

AzHHA

Thoughtful Life Conversations

ARIZONA MEDICAL LIVING WILL

This Medical Living Will is effective only while I am unable to make or communicate my healthcare decisions. If I'm so sick I could die soon, I want everyone who cares for me to know what healthcare I want when I am not able to tell them myself. Please initial your preferences below.

1. _____ **I want ALL life support treatments** that my medical providers think might help. (*If you initial here, do not initial sections 2 or 3.*)

OR

2. _____ **I want my medical providers to try life support treatments** that they think might help, except I **do not want** the following treatments (check the boxes below):

CPR	☐ No	Dialysis	☐ No
Breathing Machine	☐ No	Antibiotics	☐ No
Feeding Tubes	☐ No	Blood Transfusions	☐ No
IV Fluids	☐ No		

3. _____ **I DO NOT want life support treatments.** I want to focus on being comfortable. I want to have a natural death.

Attached are additional directions to this Living Will: (Please check) ☐ DNR or Prehospital Medical Care Directive ☐ Arizona Provider Orders for Life-Sustaining Treatment ☐ Additional Statements/Desires: _____

Organ Donation:
Do you want to be an organ, eye and/or tissue donor? (Initial Yes or No) Yes _____ No _____
If yes, circle what you want donated: any organ eye tissue or Specify: _____

Signature: This is a legal document. By signing it, you acknowledge that you have reviewed it carefully and it reflects your wishes. For this form to be used, you must be at least 18 years old and have a witness or notary watch you sign this form.

Sign Your Name | Today's Date | Date of Birth

Print Your First Name | Print Your Last Name | Address:

Witness
I was present when this Medical Living Will was signed and dated. The person seemed to be thinking clearly and was not forced to sign this Medical Living Will. I also promise that I am: 1) at least 18 years of age; 2) not the person's medical decision maker; 3) not part of the person's healthcare team; 4) not related by blood, marriage, or adoption; and 5) not going to get any part of the person's estate (such as money or property) after he/she dies.

Witness Signature | Date

Witness Print First Name | Witness Print Last Name | Address:

This document may be notarized instead of witnessed (optional).

State of Arizona)
County of _____)

On this ____ day of _____, 20____, before me personally appeared _____ whose identity was proven and he or she appeared to be of sound mind and free from duress, fraud or undue influence and he or she signed the above document.

NOTARY PUBLIC

[Affix Seal Here]

We encourage you to also complete your Healthcare Power of Attorney. Talk about this form and your wishes about your healthcare with your Healthcare Power of Attorney, your medical provider(s), and your loved ones. Give each of them a copy of this form. You should review this form often and update as needed. You may cancel this form at any time.

Life Care Planning Packet

Advance Directives for Health Care Planning

ATTORNEY GENERAL STATE OF ARIZONA

Office of the Attorney General of Arizona
Mark Brnovich

Mail completed forms to:
Arizona Secretary of State
Attn: Advance Directive Dept.
1700 W. Washington Street
Phoenix, AZ 85007

Living Will

- Legal document
- Outlines in writing your desires for treatment in the event you are unable to make decision
- Can include wishes for autopsy, organ donation and funeral planning
- Sometimes confused with a Will (a will involves the distribution of property and money after someone dies)

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Durable Healthcare Power of Attorney

- May be referred to as a Surrogate Decision Maker, Agent or Proxy
- Can make decisions over the phone (does not have to be local
- Choose someone who
  - Can advocate for you and follow your wishes
  - Talk to the healthcare team and ask questions
  - Is available and willing to accept responsibility
- Discuss your wishes with this person

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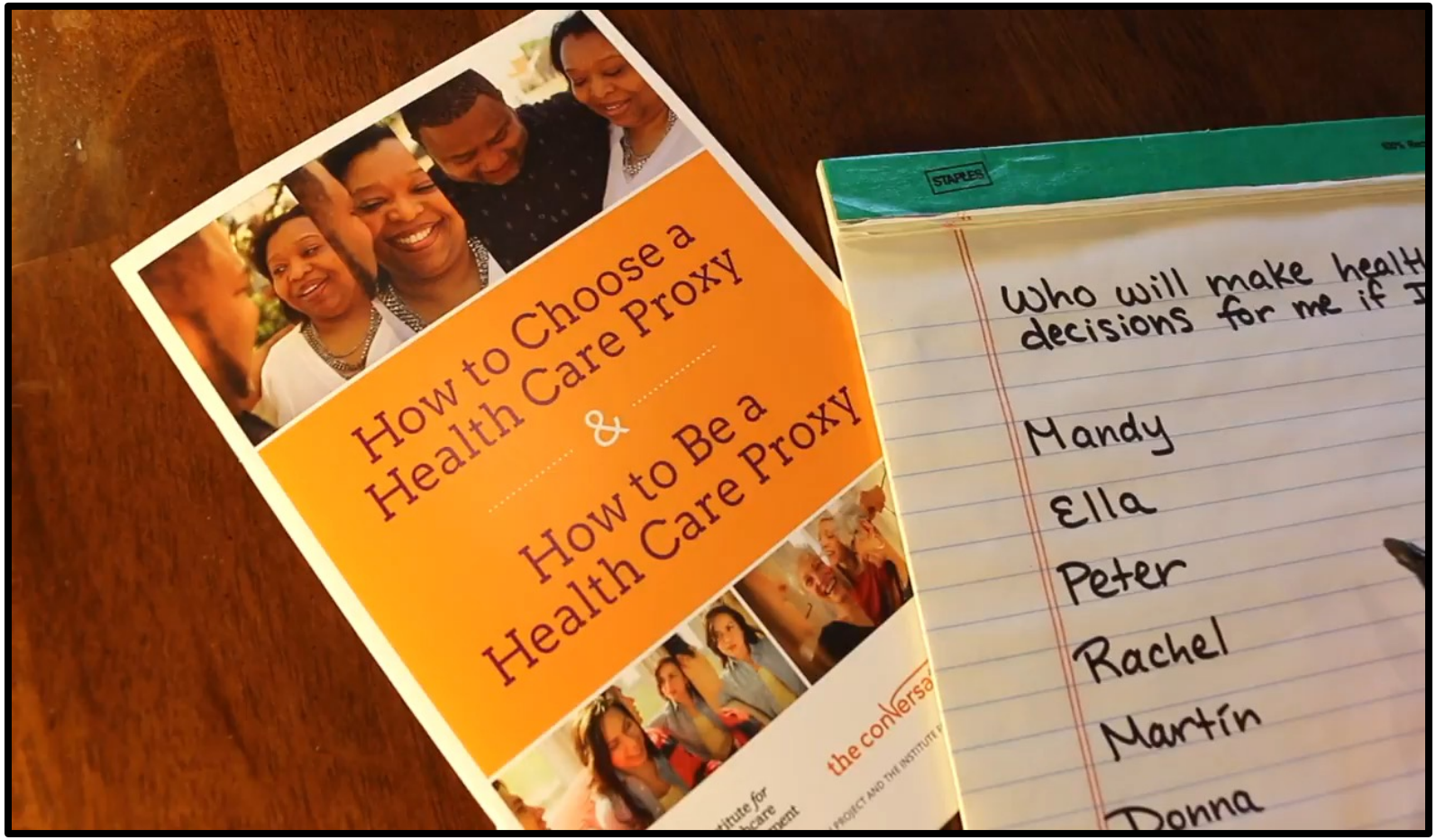
Who Will Speak For You?



View the above video here:
https://www.youtube.com/watch?v=iTxv-20ULwQ

Who Speaks for You If You Cannot Speak for Yourself?

1) Representative named in Health Care Power of Attorney
2) Surrogate
    a) Spouse
    b) Adult Child
    c) Parent
    d) If unmarried, domestic partner
    e) Sibling
    f) Close Friend
3) Your physician in consultation with hospital ethics committee
4) Physician in consultation with 2nd physician
5) Court appointed guardian

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Mental Healthcare Power of Attorney

- Allows you to authorize an agent to make decisions if you are unable to make mental healthcare decisions due to mental or physical illness, injury, disability or incapacity including Alzheimer's and dementia.
- Important with inpatient care for behavioral health services are needed
- Can be a part of a single document that includes the living will and healthcare power of attorney or can be a stand-alone document

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Prehospital Medical Care Directive

- AKA “the orange form” because it is printed on orange paper
- Directs EMS to not start CPR
- EMS does not follow a Living Will
- Usually this is for people with advanced or terminal illness or end of life
- Must be signed by the patient and a healthcare provider
- Must be printed on orange paper
- Even if you have a living will stating that you do not want to be resuscitated it will not be followed by EMS because it is not signed by a provider

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CPR Facts

15% of people who have CPR live through it.
Your chances of living through CPR in a hospital is 20%

CPR was designed to save troops on the battlefield. It was never intended to be used with the frail and elderly or those with end stage disease.

Known complications from CPR that should be part of every informed consent

50% will have brain damage that will never get better
97% will have broken ribs
59% will have bruising to the chest

- **People with late stages of cancer (1% survival)**
- **Elderly, frail**
- **Those with chronic medical disease**

Who is <u>least likely</u> to live after CPR?

Decision Guides on life-sustaining treatments. (2014). Retrieved December 28, 2018, from https://coalitionccc.org/tools-resources/decision-guides/

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POLST

- A **process** designed to improve patient care by creating a **system** using a **portable medical order** form that **records patients' wishes for treatment**
- Starts with a conversation
  - Values, beliefs, goals of care, diagnosis, prognosis, treatment options (benefits and burdens)
- Valid across all settings of care
- Only used for individuals with a serious illness or frailty toward the end of life
- **Always voluntary**

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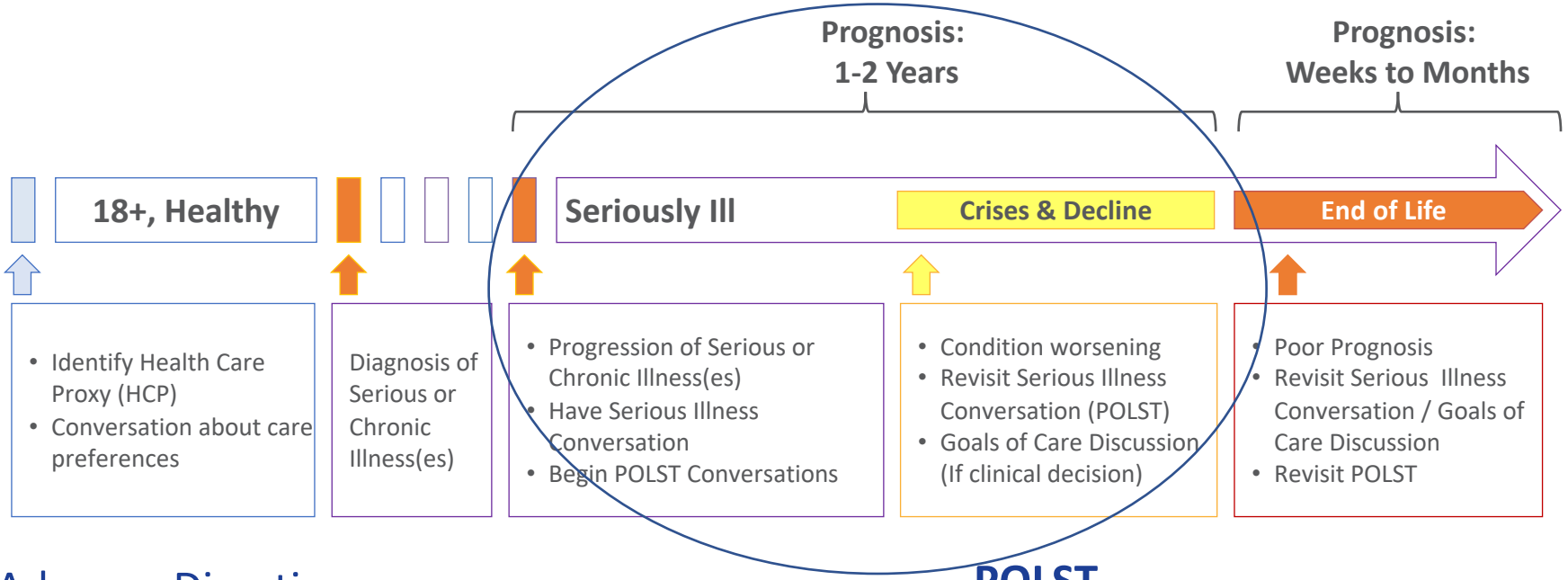
The right conversation at the right time…
helps ensure the right care at the right time



Advance Directive

- Planning for future care

POLST

Goals of Care and POLST discussions begin with the progression of serious illness and should be revisited with clinical progression/crisis/poor prognosis

POLST Addresses Gaps

Healthcare Directives

- Can be vague, open to interpretation
- Can be completed…
  - Long ago, before serious illness
  - Without considering goals of care
  - Without discussion with a provider about benefits and burdens of specific treatments
- Many times are not available when needed
- Prehospital medical directives address DNR only

Surrogates

- Often don't know patient's preferences for specific treatments
- May not agree
- Find life sustaining treatment decisions emotionally difficult

POLST

- Protects people with a DNR so they can get the care they want

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Arizona POLST Legislation

ARS § 36-3209B: In the event of a conflict between a healthcare directive (or surrogate decision) and a POLST form, the former is presumed to represent patients' wishes.

- Conflicts between POLST and AD could arise if old directives not invalidated or updated with POLST
- To reduce chance of conflict, all documents should align and patient, agent/surrogate and loved ones should be in agreement on the patient's treatment decisions/goals

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Population Intended for POLST

- Patients who are considered to be at risk for a life-threatening clinical event because they have a serious life-limiting medical condition
- Includes frailty
- Patients for whom their provider would **not** be surprised if they died within 1-2 years

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HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/_____ State where form was completed: _____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)

☐ NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ Full Treatments (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ Selective Treatments. Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ Comfort-focused Treatments. Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Discussed but no decision made (standard of care provided)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

If other than patient, print full name: | Authority:

The most recently completed valid POLST form supersedes all previously completed POLST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) **Verbal orders are acceptable with follow up signature.**

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) | Date (mm/dd/yyyy): Required ___/___/___ | Phone #: (___)

Printed Full Name: | License/Cert. #:

Supervising physician signature: ☐ N/A | License #:

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

POLST Form Elements

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information.	**Having a POLST form is always voluntary.**
This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form	Patient First Name: _____ Middle Name/Initial: _____ Preferred name: _____ Last Name: _____ Suffix (Jr, Sr, etc): _____ DOB (mm/dd/yyyy): ____/____/_____ State where form was completed: _____ Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1	☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)	☐ NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)

Section A focus is Cardiopulmonary Resuscitation Orders

- Requires informed consent on likelihood of surviving CPR, risks, benefits and alternatives discussion with shared decision making
- If the patient is 1) not breathing and has no pulse, and 2) has chosen "DNR" then no defibrillator (including AED) or chest compressions should be used

Arizona POLST

Survival Data

- Different articles define survival differently
  - Survival to discharge versus survival to home with good neurologic function

- Overall
  - Survival of inpatient CPR ~15%
  - Survival of out-of-hospital CPR ~8%
  - Survival of CPR in the nursing home ~2%
  - Patients >65 ~10%
  - Cancer patients ~ 6%
  - GO-FAR estimates ~1-27%

Reisfeld Resuscitation 2006
Ebell JAMA Internal Med 2013
Thompson Resuscitation 2018
Pape Resuscitation 2018
Zahar Am J Hosp Pall Med

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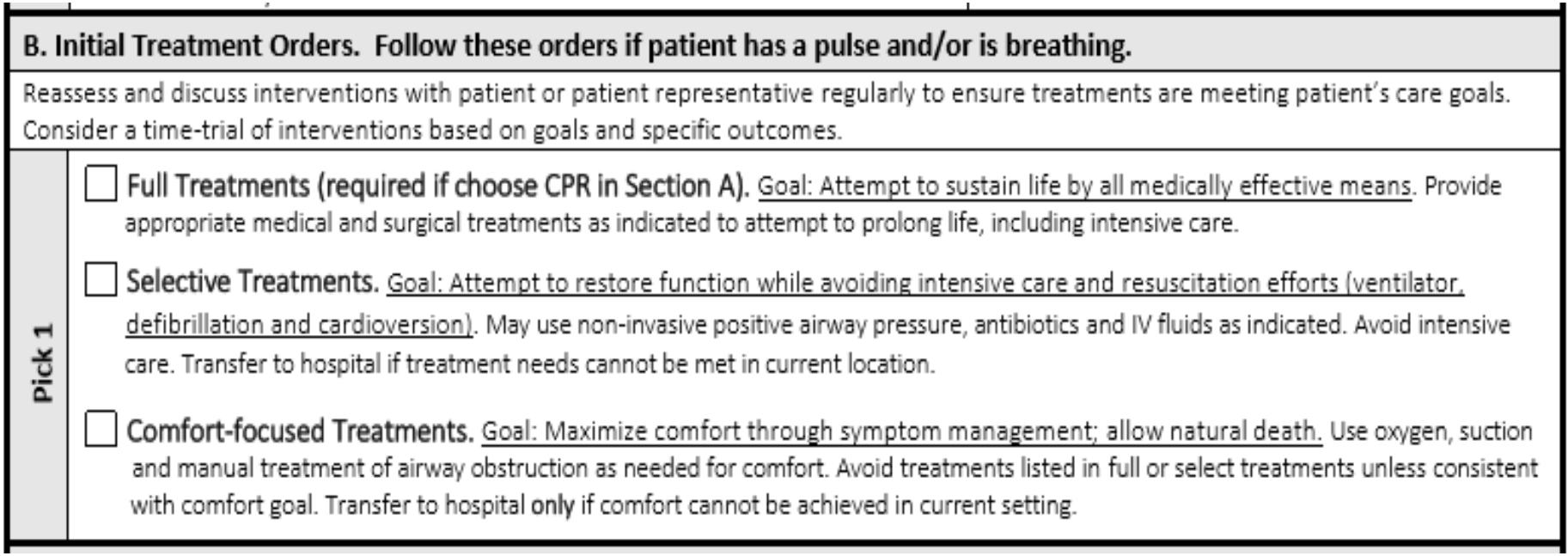

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

Section B: Initial Treatment Orders

- Requires a goals of care conversation with the patient/agent/surrogate to determine their treatment choices
- If comfort care cannot be achieved in the current setting, the patient should be transferred to a setting able to provide comfort

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C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

Section C: Additional Orders or Instructions

In your goals of care conversation there are specific treatments/interventions the patient has strong wishes on, write them here

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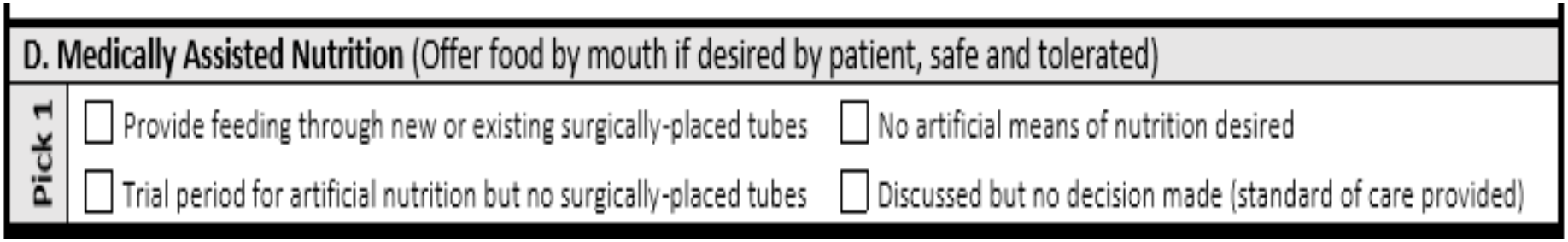

Section D: Medically Assisted Nutrition

- Remember that POLST is for "current care" not future care
- It is normal to have diminished appetite with serious illness
- Harm sometimes outweighs the benefits; may not extend life and may increase suffering (advanced dementia)

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Completing the POLST Form

- The healthcare provider:
  - Completes the POLST form after each section is discussed with the patient, agent/surrogate
  - Summarizes the goals of care conversation
  - Reviews the patient's decision & affirms commitment
  - Signs the POLST form only after the patient has signed it
- The patient:
  - Signs the completed POLST form

Tip: Ensure the Living Will is up to date with POLST

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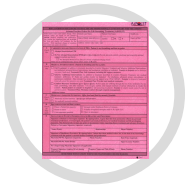
Summary: POLST Key Concepts

Voluntary

The patient or surrogate decision-maker must agree to having a POLST form.

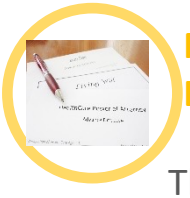


POLST Form Completed

The POLST form is a portable medical order to support patients transitioning to different care settings.

Discussion

Diagnosis, prognosis, treatment options and goals of care



Not A Healthcare Directive

The POLST form does not take the place of a Healthcare Directive. The health-care directive should be updated to align with the treatment options on the POLST form (patient choice).

Shared Decision Making

The discussion results in informed consent and shared decision making for medical treatments.

Share The POLST Form

Your healthcare provider will keep the original, put a copy in your EMR and it will go into the Health Information Exchange (so other healthcare professionals can access it). Give your agent/surrogate a copy and put a copy on your refrigerator

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For more information: www.azpolst.org and www.nationalpolstparadigm.org

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What To Do With Your Healthcare Directive Documents?

- Share your documents widely.
- Give a copy to your health care representative.
- Make copies for your loved ones.
- Discuss with your doctor; get it into your medical record.
- Keep a copy yourself.
- Send a copy to the Arizona Healthcare Directive Registry.
- Take it with you to the hospital.

Note: Photocopies are just as valid as originals.

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Registering Advance Directives and POLST

https//healthcurrent.org/azhdr/

- AZ has a new Healthcare Directives Registry
  - Housed at Contexture -- Arizona's Health Information Exchange
- Use the public facing portal
  - Providers and people can submit advance directive
- POLST will be included IF ATTACHED to the Advance Directives
- In the future, EMS will have access to the registry so they can identify if a person has an Advance Directive/POLST/Pre-Hospital directive prior to arriving on scene

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When Should You Review and Update Your Health Care Directive?

- Important life changes

  Marriage, Birth, Divorce, Deaths
- Major Illness
- New Diagnosis
- Change in treatment plan
- Change in your wishes
- Transfer from one care setting to another
- On a periodic basis

Keep Your Wishes Up To Date!

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Interprofessional Team

- A team-based approach is essential with the national shortage of primary care providers
- Multiple conversations with various team members may occur before advance directives are documented
- Any trained ACP facilitators can participate
- Team-based ACP processes, including ACP group visit models can be integrated into primary care and long-term care settings
- ACP can occur in community-based clinics, long-term and subacute care facilities, academic clinics
- ACP education can be shared
- Public awareness campaigns are effective

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Community Resources

- Structured evidence-based decision tools improve patient knowledge and preparation for shared decision making for treatment choices, including
  - ACP, palliative care and goals of care communication
  - Feeding options in dementia
  - Lung transplant in cystic fibrosis
  - Truth telling in terminal cancer
- Local resources and assistance are available
  - Classes at libraries, senior centers, and community centers, houses of worship

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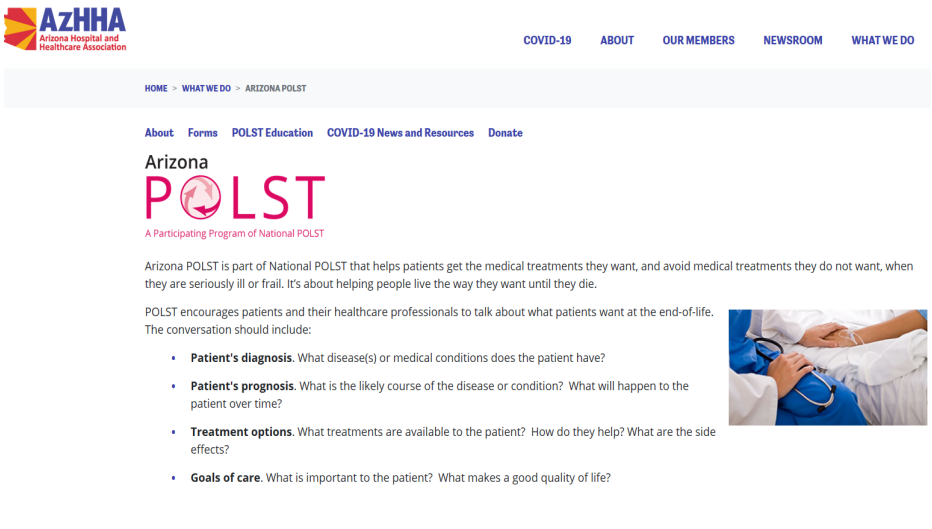
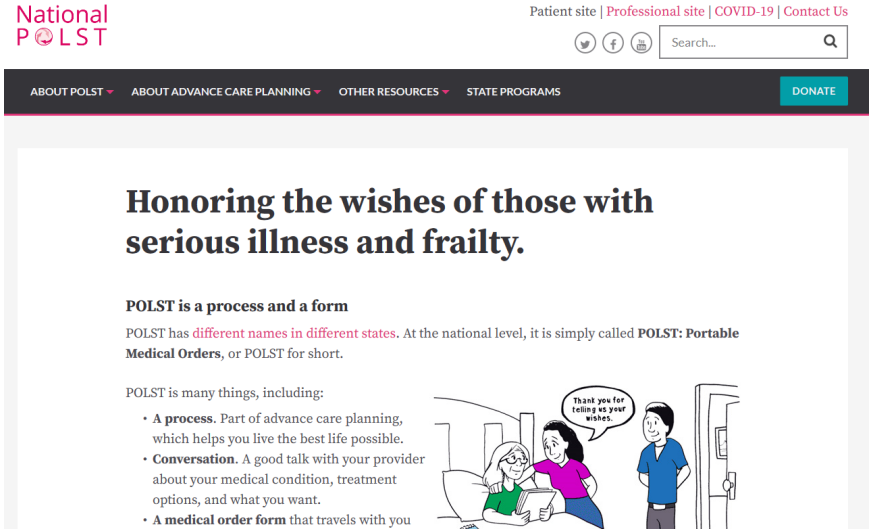
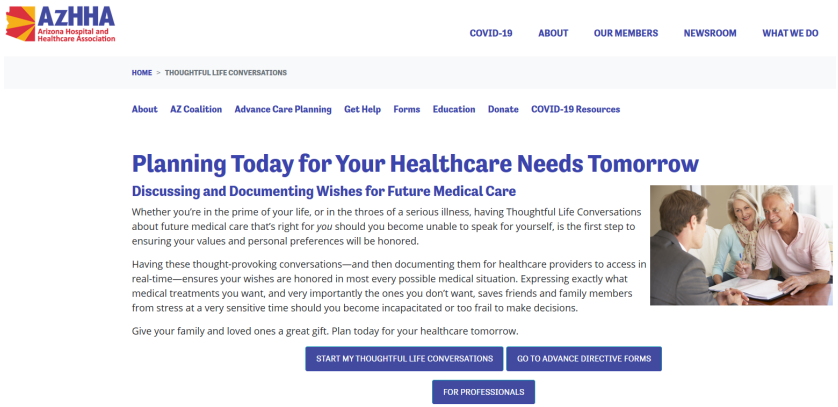
Resources



https://arizonapolst.org



www.polst.org



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www.thoughtfullifeconversations.org

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THANK YOU

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