Advance Care Planning

Getting Started

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

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COLORADO
Department of Public Health & Environment

What we mean by “Advance Care Planning” and “Advance Directives”

If you were to become unable to make your own decisions or speak for yourself, how would your loved ones and healthcare team know what your preferences were?

Preferences might include what care you want, who you want involved in your care, and, importantly, what treatments/interventions you do NOT want.

Advance Care Planning is the ongoing process of thinking about and expressing your wishes about your healthcare choices.

Advance Directives are written forms indicating your preferences.

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Why is this important?

- Empower yourself and have your voice heard.
- Promote good collaboration with your healthcare team
- Gift to your Loved Ones

- What can happen without Advance Directives:
  - Caregiver distress
  - Family conflict
  - Your wishes not as able to be honored
  - Terry Schiavo – 1995

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Why talking matters

Sharing your wishes for end-of-life care can bring you closer to the people you love. It's critically important. And you can do it. Consider the facts:

92% of people say that talking with their loved ones about end-of-life care is important.

32% have actually done so.

Source: The Conversation Project National Survey (2018)

21% of people say they haven't had the conversation because they don't want to upset their loved ones.

53% say they'd be relieved if a loved one started the conversation.

95% say they are willing or want to talk about their end-of-life wishes.

Source: The Conversation Project National Survey (2018)

80% of people say that if seriously ill, they would want to talk to their doctor about wishes for medical treatment toward the end of their life.

18% report having had this conversation with their doctor.

Source: Survey of Californians by the California HealthCare Foundation (2012) and Kaiser Family Foundation Serious Illness in Late Life Survey (2017)

97% of people say it's important to put their wishes in writing.

37% have actually done it.

Source: Kaiser Family Foundation Serious Illness in Late Life Survey (2017)

-From The Conversation Project Starter Kit

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Types of Advance Directives:

Who will make medical decisions for me if I can't?

1. Medical Durable Power of Attorney
2. Proxy Decision Maker

   Colorado is not a 'Next of Kin' state for healthcare decisions
3. Guardian

MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

I. APPOINTMENT OF AGENT AND ALTERNATES

I, _____ ,
Declarant, hereby appoint:

_____
Name of Agent

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, or refuse, or stop any healthcare, treatment, service, or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

_____
Name of Alternate Agent #1

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

_____
Name of Alternate Agent #2

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

II. WHEN AGENT'S POWERS BEGIN

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either (***initial one***):

_____ (*Initials*) Immediately upon my signature.

_____ (*Initials*) When my physician or other qualified medical professional has determined that I am unable to make my or express my own decisions, and for as long as I am unable to make or express my own decisions.

III. INSTRUCTIONS TO AGENT

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines is in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

My signature below indicates that I understand the purpose and effect of this document:

_____
Signature of Declarant *Date*

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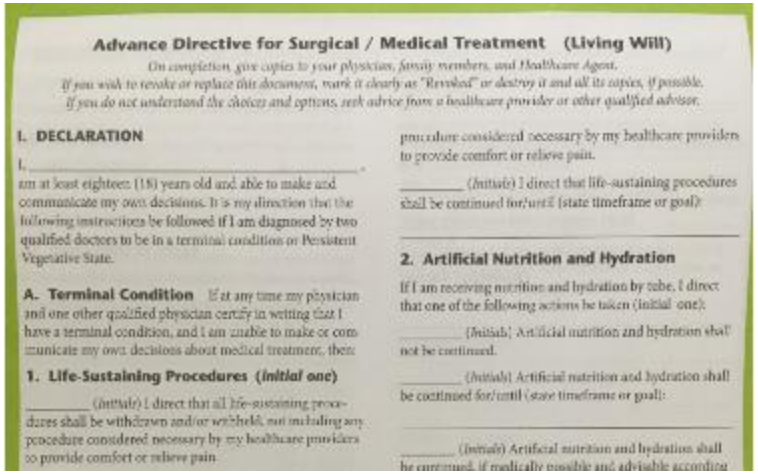
Types of Advance Directives:

What Kind of Medical Care and Treatment do I want to have?

Living Will



Advance Directive for Surgical / Medical Treatment (Living Will)

On completion, give copies to your physician, family members, and Healthcare Agent.
If you wish to revoke or replace this document, mark it clearly as "Revoked" or destroy it and all its copies, if possible.
If you do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.

I. DECLARATION

I, _____,
am at least eighteen (18) years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

A. Terminal Condition If at any time my physician and one other qualified physician certify in writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

1. Life-Sustaining Procedures (*initial one*)

_____ (Initials) I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (Initials) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

2. Artificial Nutrition and Hydration

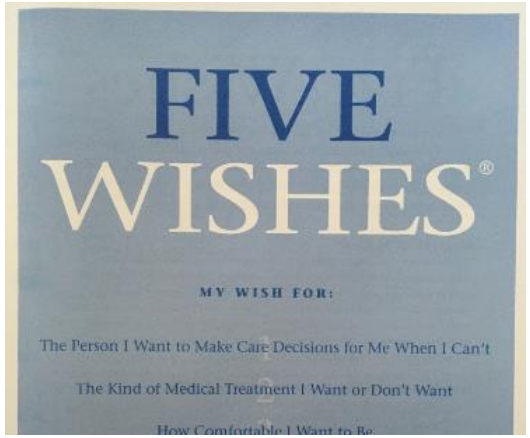
If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (Initials) Artificial nutrition and hydration shall not be continued.

_____ (Initials) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____ (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according

Five Wishes



FIVE WISHES®

MY WISH FOR:

The Person I Want to Make Care Decisions for Me When I Can't

The Kind of Medical Treatment I Want or Don't Want

How Comfortable I Want to Be

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What Kind of Medical Care and Treatment do I want to have?

Do Not Resuscitate (DNR) Order

Patient's or Authorized Agent's Directive to Withhold Cardiopulmonary Resuscitation (CPR)
This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2

Patient's Information

Patient's Name_____
(Printed Name)

If Applicable- Name of Agent/Legally Authorized Guardian/Parent of Minor Child _____
(Printed Name)

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Eye Color: _____ Hair Color: _____

Race Ethnicity : ☐ Asian or Pacific Islander ☐ Black, non-Hispanic ☐ White, non-Hispanic
☐ American Indian or Alaska Native ☐ Hispanic ☐ Other

If Applicable- Name of hospice program/provider: _____

Physician's Information

Physician's Name: _____
(Printed Name)

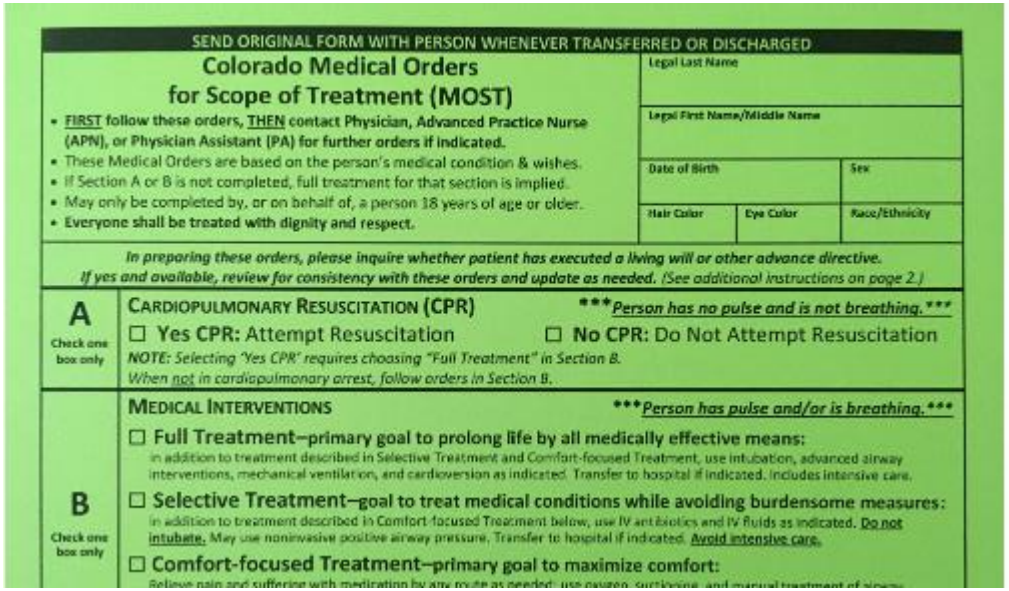
Physician's Address: _____

Physician's telephone: ( ) _____ Physician's Colorado License #: _____

Directive Attestation

Check **ONLY** the information that applies:

MOST (Medical Orders for Scope of Treatment)



SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

- FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- Everyone shall be treated with dignity and respect.

Legal Last Name | Legal First Name/Middle Name | Date of Birth | Sex | Hair Color | Eye Color | Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. (See additional instructions on page 2.)

A Check one box only — CARDIOPULMONARY RESUSCITATION (CPR) ***Person has no pulse and is not breathing.***
☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation
NOTE: Selecting "Yes CPR" requires choosing "Full Treatment" in Section B. When not in cardiopulmonary arrest, follow orders in Section B.

B Check one box only — MEDICAL INTERVENTIONS ***Person has pulse and/or is breathing.***
☐ **Full Treatment–primary goal to prolong life by all medically effective means:** in addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.
☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:** in addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. Do not intubate. May use noninvasive positive airway pressure. Transfer to hospital if indicated. Avoid intensive care.
☐ **Comfort-focused Treatment–primary goal to maximize comfort:**

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SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

- **FIRST** follow these orders, **THEN** contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

Legal Last Name		
Legal First Name/Middle Name		
Date of Birth		Sex
Hair Color	Eye Color	Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive.
If yes and available, review for consistency with these orders and update as needed. *(See additional instructions on page 2.)*

A — Check one box only

CARDIOPULMONARY RESUSCITATION (CPR)

Person has no pulse and is not breathing.

☐ Yes CPR: Attempt Resuscitation ☐ No CPR: Do Not Attempt Resuscitation

NOTE: *Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B.*
When not in cardiopulmonary arrest, follow orders in Section B.

B — Check one box only

MEDICAL INTERVENTIONS

Person has pulse and/or is breathing.

☐ **Full Treatment**–primary goal to prolong life by all medically effective means:
In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **Selective Treatment**–goal to treat medical conditions while avoiding burdensome measures:
In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. Do not intubate. May use noninvasive positive airway pressure. Transfer to hospital if indicated. Avoid intensive care.

☐ **Comfort-focused Treatment**–primary goal to maximize comfort:
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

Additional Orders: _____

C — Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION

Always offer food & water by mouth if feasible.

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section ***does not*** imply any one of the choices—further discussion is required. ***NOTE:*** *Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

Additional Orders: _____

D

DISCUSSED WITH (check all that apply):

☐ Patient
☐ Agent under Medical Durable Power of Attorney
☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6))
☐ Legal guardian
☐ Other:_____

SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (*MANDATORY*)

Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Durable Power OA, CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these *Medical Orders for Scope of Treatment*, they shall remain in full force and effect.

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.

Patient/Legal Decision Maker Signature (Mandatory)	*Name (Print)*	*Relationship/ Decision maker status (Write "self" if patient)*	*Date Signed (Mandatory; Revokes all previous MOST forms)*

Physician / APN / PA Signature (Mandatory)	*Print Physician / APN / PA Name, Address, and Phone Number*	*Date Signed (Mandatory)*
Colorado License #:		

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

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Where do I get an Advance Directive Form?

The Conversation Project http://theconversationprojectinboulder.org/

Your Right to Make Healthcare Decisions Booklet (includes Living Will, DNR, MDPOA) https://cha.com/wp-content/uploads/2017/03/medicaldecisions_2011-02.pdf

Colorado Care Planning Website (Content in English, Spanish, and Large Text)
https://coloradocareplanning.org/

Five Wishes https://fivewishes.org/Home

COVID-19 TCP Presentation to learn advance care planning basics.
https://www.youtube.com/watch?v=34_Rsb3HXeU&feature=youtu.beLink to The Conversation Project's Being Prepared in the Time of COVID-19 Guide

COVID19 Treatment Decision Guide If you go to the hospital and become seriously ill, these are the questions you will likely be asked. http://theconversationprojectinboulder.org/wp-content/uploads/2020/04/One-Page-COVID-19-Treatment-Decision-Support-Guide-.pdf

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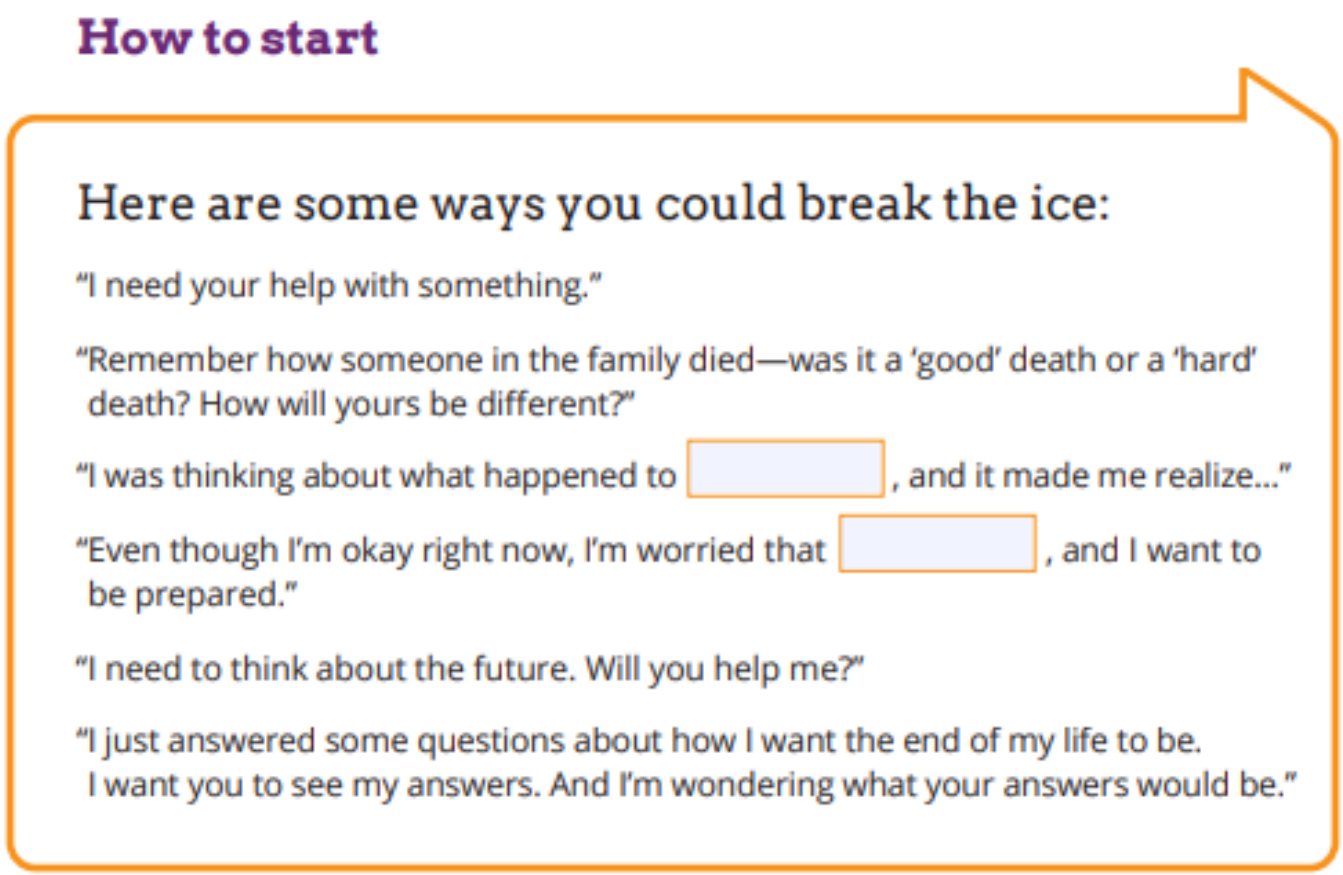
When and How do I start the conversation?



How to start

Here are some ways you could break the ice:

"I need your help with something."

"Remember how someone in the family died—was it a 'good' death or a 'hard' death? How will yours be different?"

"I was thinking about what happened to _____, and it made me realize..."

"Even though I'm okay right now, I'm worried that _____, and I want to be prepared."

"I need to think about the future. Will you help me?"

"I just answered some questions about how I want the end of my life to be. I want you to see my answers. And I'm wondering what your answers would be."

-From The Conversation Project Starter Kit

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What to talk about:

- ☐ When you think about the last phase of your life, what's most important to you? How would you like this phase to be?
- ☐ Do you have any particular concerns about your health? About the last phase of your life?
- ☐ What affairs do you need to get in order, or talk to your loved ones about? *(Personal finances, property, relationships)*
- ☐ Who do you want (or not want) to be involved in your care? Who would you like to make decisions on your behalf if you're not able to? *(This person is your health care proxy.)*
- ☐ Would you prefer to be actively involved in decisions about your care? Or would you rather have your health care team do what they think is best?
- ☐ Are there any disagreements or family tensions that you're concerned about?
- ☐ Are there important milestones you'd like to be there for, if possible? *(The birth of your grandchild, your 80th birthday.)*
- ☐ Where do you want (or not want) to receive care? *(Home, nursing facility, hospital)*
- ☐ Are there kinds of treatment you would want (or not want)? *(Resuscitation if your heart stops, breathing machine, feeding tube)*
- ☐ When would it be okay to shift from a focus on curative care to a focus on comfort care alone?

This list doesn't cover everything you may need to think about, but it's a good place to start. Talk to your health care team if you'd like them to suggest more questions to talk about.

REMEMBER:

- Be patient. Some people may need a little more time to think.
- You don't have to steer the conversation; just let it happen.
- Don't judge. A "good" death means different things to different people.
- Nothing is set in stone. You and your loved ones can always change your minds as circumstances change.
- Every attempt at the conversation is valuable.
- This is the first of many conversations—you don't have to cover everyone or everything right now.

-From The Conversation Project Starter Kit

Planning does not mean giving up hope!

Knowledge is the Enemy of Fear

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Questions?

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