Alphabet Soup:
Understanding medical Advance Care planning

Tulsa Estate Planning Forum

September 12, 2016

Roadmap

Healthcare…where are we in the US?

What is Palliative Care?

Advance Care Planning

- Where are we in the US?

Healthcare

Chronic Illness

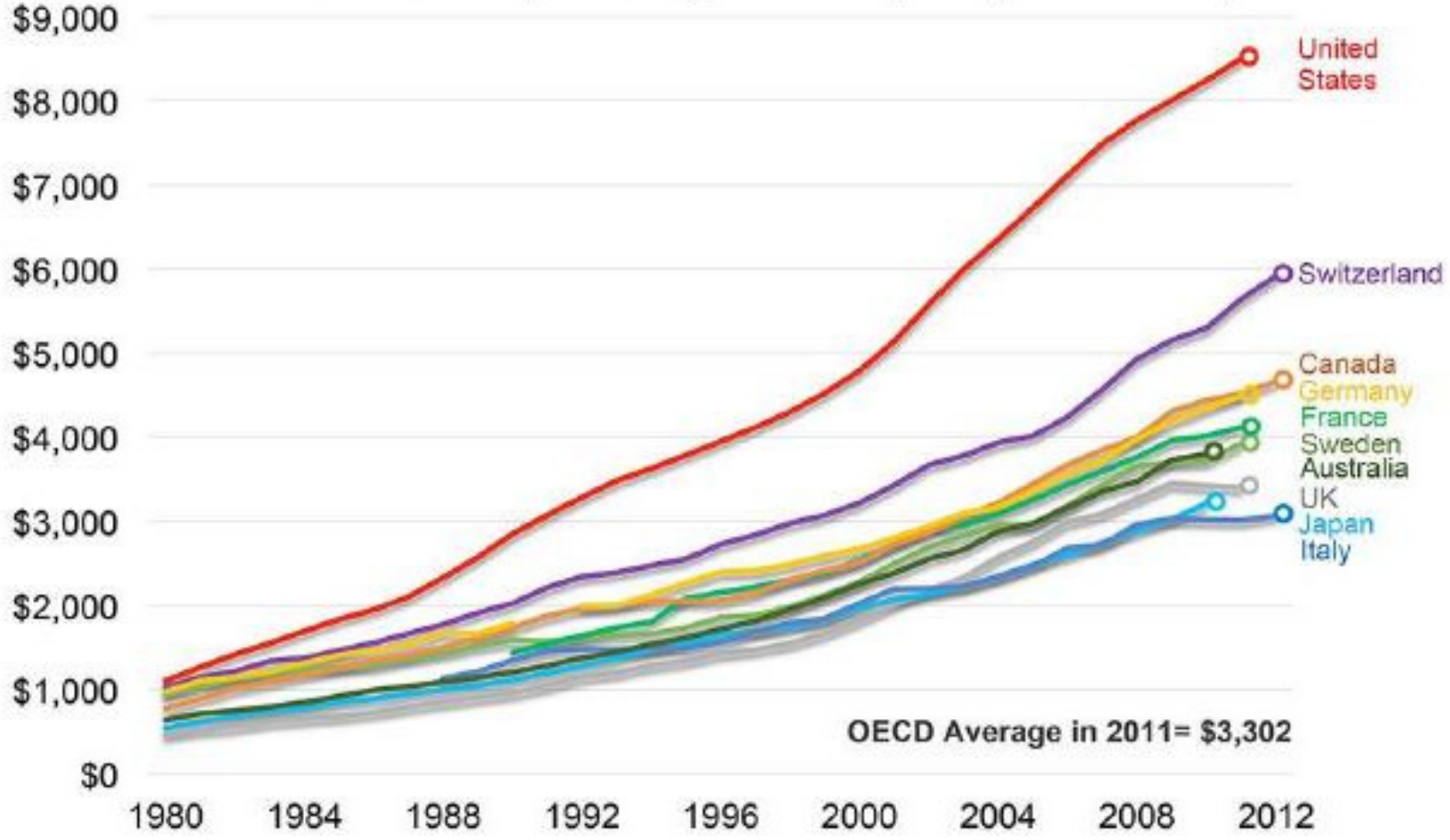
Most people will live with chronic illness(es)

There is a 90% chance patients will grow older with worsening medical problems

The ‘C’ Diseases:

- *Cancer*
- *Congestive Heart Failure*
- *Cerebrovascular Accident*
- *Coronary Artery Disease*
- *Chronic Obstructive Pulmonary Disease*
- *Chronic Kidney Disease*
- *Cardiomyopathies*
- *Cirrhosis and Hepatic Failure*
- *Alzheimer’s Disease and other Dementias*

Health Care Spending Per Capita ($US PPP)



Soure: OECD Health Data 2013.
Data note: PPP = purchasing power parity.
Produced by Veronique de Rugy, Mercatus Center at George Mason University.

Intermountain Healthcare

What do we do?

Medical Paradigm Shift

We need to move into thinking of our
TOTAL HEALTH

Where our needs are delivered with
HIGH TOUCH

And *only when necessary* we use
RESCUE CARE

What is Palliative Care?

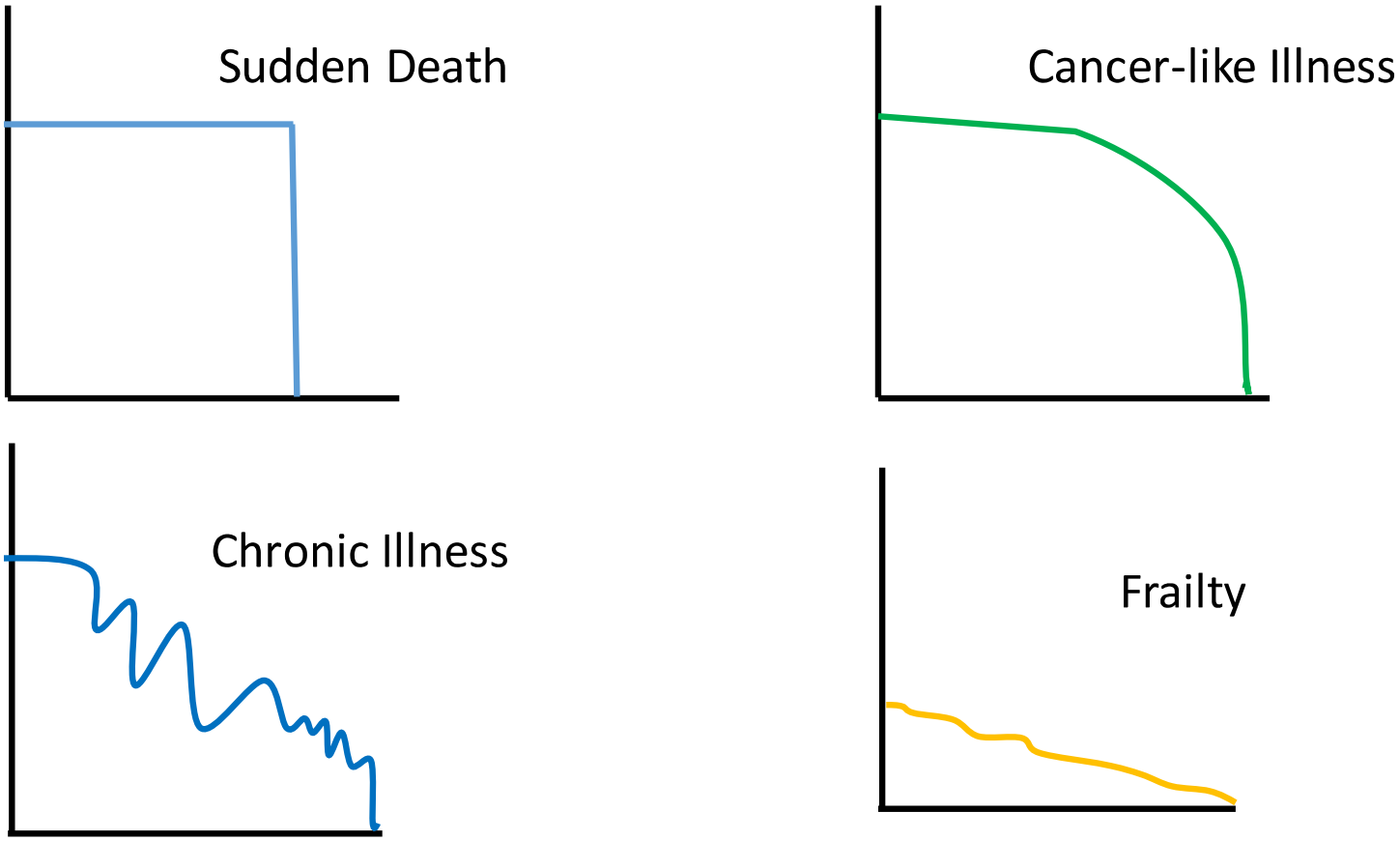
Palliative Care

- **Palliative care is specialized medical care for people with *serious illnesses.***
- **This type of care is focused on *providing patients with relief* from the symptoms, pain, and stress of a serious illness - whatever the diagnosis.**
- **The goal is to *improve quality of life* for <u>both</u> the patient and the family.**
- **Palliative care is *provided by a team* of doctors, nurses, and other specialists who work with a patient's other doctors to provide an *extra layer of support*.**
- **Palliative care is appropriate at *any age* and at *any stage* in a serious illness, and can be provided together with curative treatment.**

Models of Palliative Care Delivery

- Hospice
- Inpatient programs
- Outpatient programs
- Community palliative care programs

Trajectories of illness…



Adapted from Lunney, 2003

How does it work?

- All clinicians should have a basic knowledge to address the palliative care needs of patients living with serious illness

- For those that care complex---PC Consultant delivery model…to:

    - Address the domains of Palliative Care
        - Advance decision making and ***prognostication***
        - Complex symptom management
        - Psycho-social assessments and interventions
        - Spiritual/existential

- For the healthcare system---PC is Forging the understanding of Shared Decision making—
    - Finding the happy medium between paternalism and patient sovereignty

THE NEW YORKER
August 2, 2010

LETTING GO

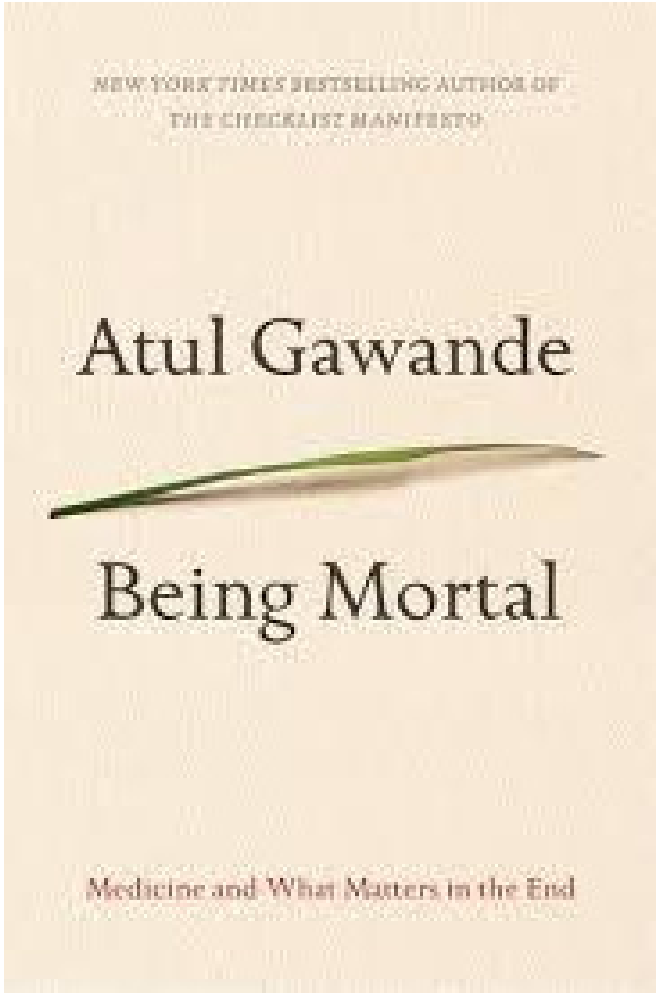
What should medicine do
when it can't save your life?

By Atul Gwande

BJ Miller:
What really matters at the end of life
TED2015 · 19:07 · **Filmed** Mar 2015

GET PALLIATIVE CARE

getcpalliativecare.org



Advance Care Planning

Advanced Directives

DNR

POLST

Advance Directives

Advance Directives

- Living Will
- Health Care Proxy
- Organ Donation
- General provisions

Advance Directive for Health Care

This form (in English, Vietnamese and Spanish) and answers to frequently asked questions (FAQS) are available at this web address: http://okpalliative.nursing.ouhsc.edu/oklaw.htm

OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

I. Living Will

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

1. If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:
(Initial only one option)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.
(Initial if applicable)

See my more specific instructions in paragraph (4) below.

2. If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:
(Initial only one option)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

- Only can be done *in ADVANCE* when a patient has capacity.

- Kicks in only if patient is:
  1. Incapacitated AND
  2. Diagnosed/Prognosed with a qualifying condition
     - -Terminal
     - -PVS
     - -End Stage

- Only addresses the role of:
  - -ANH
  - -Life sustaining treatment

Be careful what you wish for…What to write in section “other”?

-direction of care if not qualifying condition

-time trials

-burial wishes

-fears of debility, illness, death

_____ I direct that I be given life-sustaining treatment and, if I am unable to ta
food and water by mouth, I wish to receive artificially administered nutrition an
hydration.
(Initial if applicable)

_____ See my more specific instructions in paragraph (4) below.

3. If I have an end-stage condition, that is, a condition caused by injury, diseas
illness, which results in severe and permanent deterioration indicated by
incompetency and complete physical dependency for which treatment of the
irreversible condition would be medically ineffective:
(Initial one option only)

_____ I direct that my life not be extended by life-sustaining treatment, except
am unable to take food and water by mouth, I wish to receive artificially admin
nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, includ
artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to ta
and water by mouth, I wish to receive artificially administered nutrition and hyc
(Initial if applicable)

See my more specific instructions in paragraph (4) below

4. Other.
(Here you may: [a] describe other conditions in which you would want life-sust
treatment or artificially administered nutrition and hydration provided, withheld
withdrawn; [b] give more specific instructions about your wishes concerning lif
sustaining treatment or artificially administered nutrition and hydration if you ha
terminal condition, are persistently unconscious, or have an end-stage conditi
[c] do both of these.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

II. My Appointment of My Health Care Proxy

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of:

_____, whom I appoint as my health care proxy.

If my health care proxy is or becomes unable or unwilling to serve, I appoint:

_____ as my alternate health care proxy with the same authority.

My healthcare proxy is authorized to make whatever health care decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

III. Anatomical Gifts

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:
(Initial all that apply)

_____ transplantation therapy
_____ advancement of medical science, research, or education
_____ advancement of dental science, research, or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. I specifically donate:
(Initial all that apply)

_____ My entire body; or

The following body organs or parts;

_____ lungs	_____ liver	_____ arteries
_____ pancreas	_____ heart	_____ glands
_____ kidneys	_____ brain	_____ tissue
_____ skin	_____ bones/marrow	_____ eyes/cornea/lens
_____ bloods/fluids	_____ tissue	_____ other

Health Care Proxy:

Kicks in when you are incapacitate for any reason…

Anatomical Gifts:

Whole body donation is different and must be done prior to death

General Provisions:

-Minors
-Pregnancy
-Legal rights and understanding

IV. General Provisions

a. I understand that I must be eighteen (18) years of age or older to execute this form.
b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.
d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.
e. This advance directive shall be in effect until it is revoked.
f. I understand that I may revoke this advance directive at any time.
g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.
i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

Signed this _____ day of _____ , 2 _____ .

_____
Signature

_____ _____
Residence (City, county, and state) | Date of birth (Optional for identification purposes)

This advance directive was signed in my presence.

_____ _____
Signature of Witness | Signature of Witness

_____ _____
Address | Address

_____ _____
City/State | City/State

For assistance in filling out this form call (405) 522-3069.

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DNR

Oklahoma DNR # 1

If patient:

- Has capacity
- No need for physician signature
- No need for notary
- Witnessed by anyone that will not gain from the death

OKLAHOMA DO-NOT-RESUSCITATE (DNR) CONSENT FORM

I, _____, request limited health care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider including, but not limited to, emergency medical services (EMS) personnel.

I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.

I understand that I may revoke this consent at any time in one of the following ways:

1. If I am under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;

2. If I am not under the care of a health care agency, by destroying my do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation;

3. If I am incapacitated and under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by written notification to a physician or other health care provider of the health care agency or by oral notification to my attending physician; or

4. If I am incapacitated and not under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by destroying the do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers. I hereby state that I am making an informed decision and agree to a do-not-resuscitate order.

_____ or _____

Signature of Person

Signature of Representative
(Limited to an attorney-in-fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Advance Directive Act or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.)

This DNR consent form was signed in my presence.

_____
Date

_____
Signature of Witness

_____
Address

_____
Signature of Witness

_____
Address

CERTIFICATION OF PHYSICIAN

This form is to be used by an attending physician only to certify that an incapacitated person without a representative would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. An attending physician of an incapacitated person without a representative must know by clear and convincing evidence that the incapacitated person, when competent, decided on the basis of information sufficient to constitute informed consent that such person would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Clear and convincing evidence for this purpose shall include oral, written, or other acts of communication between the patient, when competent, and family members, health care providers, or others close to the patient with knowledge of the patient's desires.

I hereby certify, based on clear and convincing evidence presented to me, that I believe that _____
Name of Incapacitated Person

would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Therefore, in the event of cardiac or respiratory arrest, no chest compressions, artificial ventilation, intubations, defibrillation, or emergency cardiac medications are to be initiated.

_____ _____
Physician's Signature *Physician's Name (PRINT)*

_____
Physician's Address/Phone

_____
Date

This DNR consent form and Certification of Physician is copied from Senate Bill 1325. This law is effective November 1, 2010.

This form is available online at:
http://www.okdhs.org/divisionsoffices/visd/asd/ under Quick Links

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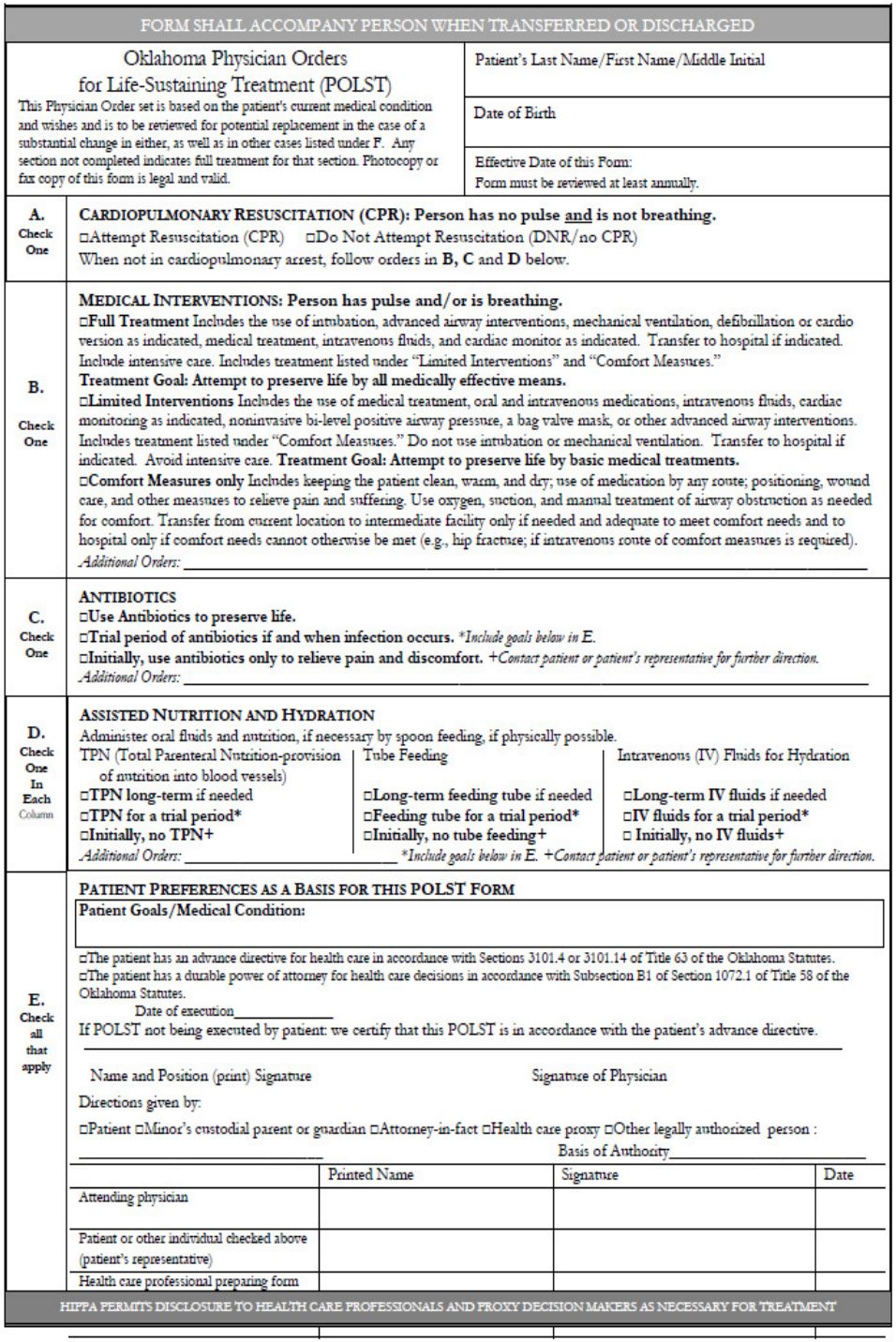
Oklahoma DNR # 2

If patient:

- Does not have capacity
- Does not have a legal representative
- Has made statements clearly indicating their wishes
- Requires physician signature

POLST



FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Oklahoma Physician Orders for Life-Sustaining Treatment (POLST)

This Physician Order set is based on the patient's current medical condition and wishes and is to be reviewed for potential replacement in the case of a substantial change in either, as well as in other cases listed under F. Any section not completed indicates full treatment for that section. Photocopy or fax copy of this form is legal and valid.

Patient's Last Name/First Name/Middle Initial

Date of Birth

Effective Date of this Form:
Form must be reviewed at least annually.

A. Check One

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
□Attempt Resuscitation (CPR) □Do Not Attempt Resuscitation (DNR/no CPR)
When not in cardiopulmonary arrest, follow orders in **B, C** and **D** below.

B. Check One

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.
□**Full Treatment** Includes the use of intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardio version as indicated, medical treatment, intravenous fluids, and cardiac monitor as indicated. Transfer to hospital if indicated. Include intensive care. Includes treatment listed under "Limited Interventions" and "Comfort Measures."
Treatment Goal: Attempt to preserve life by all medically effective means.
□**Limited Interventions** Includes the use of medical treatment, oral and intravenous medications, intravenous fluids, cardiac monitoring as indicated, noninvasive bi-level positive airway pressure, a bag valve mask, or other advanced airway interventions. Includes treatment listed under "Comfort Measures." Do not use intubation or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care. **Treatment Goal: Attempt to preserve life by basic medical treatments.**
□**Comfort Measures only** Includes keeping the patient clean, warm, and dry; use of medication by any route; positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Transfer from current location to intermediate facility only if needed and adequate to meet comfort needs and to hospital only if comfort needs cannot otherwise be met (e.g., hip fracture; if intravenous route of comfort measures is required).
Additional Orders: _____

C. Check One

ANTIBIOTICS
□**Use Antibiotics to preserve life.**
□**Trial period of antibiotics if and when infection occurs.** **Include goals below in E.*
□**Initially, use antibiotics only to relieve pain and discomfort.** *+Contact patient or patient's representative for further direction.*
Additional Orders: _____

D. Check One In Each Column

ASSISTED NUTRITION AND HYDRATION
Administer oral fluids and nutrition, if necessary by spoon feeding, if physically possible.

TPN (Total Parenteral Nutrition-provision of nutrition into blood vessels)	Tube Feeding	Intravenous (IV) Fluids for Hydration
□**TPN long-term** if needed	□**Long-term feeding tube** if needed	□**Long-term IV fluids** if needed
□**TPN for a trial period***	□**Feeding tube for a trial period***	□**IV fluids for a trial period***
□**Initially, no TPN+**	□**Initially, no tube feeding+**	□ **Initially, no IV fluids+**

Additional Orders: _____ **Include goals below in E. +Contact patient or patient's representative for further direction.*

E. Check all that apply

PATIENT PREFERENCES AS A BASIS FOR THIS POLST FORM
Patient Goals/Medical Condition:

□The patient has an advance directive for health care in accordance with Sections 3101.4 or 3101.14 of Title 63 of the Oklahoma Statutes.
□The patient has a durable power of attorney for health care decisions in accordance with Subsection B1 of Section 1072.1 of Title 58 of the Oklahoma Statutes.
Date of execution_____
If POLST not being executed by patient: we certify that this POLST is in accordance with the patient's advance directive.

Name and Position (print) Signature Signature of Physician

Directions given by:
□Patient □Minor's custodial parent or guardian □Attorney-in-fact □Health care proxy □Other legally authorized person :
_____ Basis of Authority_____

	Printed Name	Signature	Date
Attending physician			
Patient or other individual checked above (patient's representative)			
Health care professional preparing form			

HIPPA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

POLST:
Physician Orders for Life Sustaining Treatment

- On June 6, Governor Fallen signed HB3017 establishing the Oklahoma Physician Orders for Life Sustaining Treatment Act.
- On August 25, the law went into effect
- The National POLST Paradigm Committee has the accepted the form within their work frame
- POLST contains orders for Resuscitation along with:
  - -General Medical Interventions
  - -Antibiotics
  - -Artificial Nutrition and Hydration
- POLST requires a physician signatures, so does not need interpretation or prognostication as required to act on an Advance Directives

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

F.

INFORMATION FOR PATIENT OR REPRESENTATIVE OF PATIENT NAMED ON THIS FORM

The POLST form is **always voluntary** and is usually for persons with advanced illness. **Before providing information for or signing it, carefully read "Information for Patients and Their Families – Your Medical Treatment Rights Under Oklahoma Law," which the health care provider must give you. It is especially important to read the sections on CPR and food and fluids, which have summaries of Oklahoma laws that may control the directions you may give.** POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. An advance health-care directive is recommended, regardless of your health status. An advance directive allows you to document in detail your future health care instructions and/or name a health-care agent to speak for you if you are unable to speak for yourself.

The State of Oklahoma affirms that the lives of all are of equal dignity regardless of age or disability and emphasizes that no one should ever feel pressured to agree to forego life-preserving medical treatment because of age, disability, or fear of being regarded as a "burden."

If this form is for a minor for whom you are authorized to make health-care decisions, you may not direct denial of medical treatment in a manner that would violate the child abuse and neglect laws of Oklahoma. In particular, you may not direct the withholding of medically indicated treatment from a disabled infant with life-threatening conditions, as those terms are defined in 42 U.S.C. § 5106g or regulations implementing it and 42 U.S.C. § 5106a.

G.

DIRECTIONS FOR COMPLETING AND IMPLEMENTING FORM

COMPLETING POLST

POLST must be reviewed and prepared in consultation with the patient or the patient's representative after that person has been given a copy of "Information for Patients and Their Families – Your Medical Treatment Rights Under Oklahoma Law ." POLST must be reviewed and signed by a physician to be valid. Be sure to document the basis for concluding the patient had or lacked capacity at the time of execution of the form in the patient's medical record. If the patient lacks capacity, any current advance directive form must be reviewed and the patient's representative and physician must both certify that POLST complies with it. The signature of the patient or the patient's representative is required; however, if the patient's representative is not reasonably available to sign the r original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record as soon as practicable and "on file" must be written on the appropriate signature line on this form.

IMPLEMENTING POLST

If a minor protests a directive to deny the minor life-saving treatment, the denial of treatment may not be implemented pending issuance of a judicial order resolving the conflict. A health care provider unwilling to comply with POLST must comply with the transfer and treatment pending transfer requirements of Section 3101.9 of Title 63 of the Oklahoma Statutes as well as those of the Nondiscrimination in Treatment Act, Sections 3090.2 and 3090.3 of Title 63 of the Oklahoma Statutes.

REVIEWING POLST

This POLST must be reviewed at least annually or earlier if:

- The patient is admitted to or discharged from a medical care facility;
- There is a substantial change in the patient's health status; or
- The treatment preferences of the patient or patient's representative change

The same requirements for participation of the patient or patient's representative, and signature by both a physician and the patient or the patient's representative, that are described under COMPLETING POLST" also apply when POLST is reviewed, and must be documented in Section I.

H.

REVOCATION OF POLST

If POLST is revised or becomes invalid, write the word "**VOID**" in large letters on the front of the form. After voiding the form a new form may be completed. A patient with capacity or the individual or individuals authorized to sign on behalf of the patient in Section E of this form may void this form. If no new form is completed, full treatment and resuscitation is to be provided.

I.

REVIEW SECTION: Periodic review confirms current form or may require completion of new form

Date of Review	Location of Review	Patient or Representative Signature	Physician Signature	Outcome of Review
				□FORM CONFIRMED - No Change □FORM VOIDED, see updated form □FORM VOIDED, no new form
				□FORM CONFIRMED - No Change □FORM VOIDED, see updated form □FORM VOIDED, no new form
				□FORM CONFIRMED - No Change □FORM VOIDED, see updated form □FORM VOIDED, no new form
				□FORM CONFIRMED - No Change

CONTACT INFORMATION:

Patient/Representative	Relationship	Phone Number	Email Address
Health Care Professional Preparing Form	Relationship	Phone Number	Email Address

HIPPA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT