Scalable Projects in Advance Care Planning:

How to get Patients
the Care that Matters to Them –
Every Patient, Every Time, Every Place
Continuing Education Disclosures

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  - Attendance at 90% of activity required
  - Completed evaluation

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- Joint Provider: This activity is being jointly provided by the University of Colorado College of Nursing, Western Colorado Area Health Education Center (AHEC), HopeWest, and Community Hospital of Grand Junction Office of CME.
Participants

- Donna Neste, Mesa County IPA, moderator
- Craig Hughes, MD, family physician, Primary Care Partners
- Laura Campbell, MD, family physician, Juniper Family Medicine
- Carol Fowler, MD, family physician and hospice and palliative care physician, St. Mary’s Hospital and HopeWest
Disclosures

- All of the physicians subscribe to and use Quality Health Network, but have no other financial interest in this organization.
Goals and Learning Objectives

- Understand the importance of matching care with patients’ values
- Identify barriers to completing Advance Directives and how to overcome them
- Be familiar with tools for completing Advance Directives in an office setting
- Know how to share completed documents across all care settings
Panel Question # 1

• What does “Advance Care Planning” mean?
Advance Care Planning
Across the Life Continuum

18+ Years
- Complete a Medical Durable Power of Attorney (MDPOA) - Emergency Response Wishes form
- By Colorado law your spouse or other next of kin has no automatic right to make healthcare decisions for you

18-65 Years
- Complete Living Will, Five Wishes other guidelines “Serious Illness” documents

65+ Years
- Complete MOST form
- Review ACP documents with care provider
- Onset of serious illness
- Speak to your care provider about uploading your ACP documents in QHN so medical providers can access them in all care settings.
Panel Question # 2

- Why do we need better Advance Care Planning?
Panel Question #3

- Why does effective Advance Care Planning matter?
Panel Question # 4

• What are your current projects or strategies for completing Advance Directives in your work setting?
Panel Question # 5

a) What has been your experience with trying to get more advance care planning done?

b) What are the barriers and pitfalls?

c) What solutions have worked for you?
Panel Question # 6

- How do you capture conversations with patients and share the resulting documents and forms?
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 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 ______________

Pursuant to Colorado Revised Statute 15-14.503–509

Colorado Advance Directives Consortium

http://coloradoadvancedirectives.com
# Serious Illness Conversation Guide

## Conversation Flow

<table>
<thead>
<tr>
<th>Step</th>
<th>Patient-Tested Language</th>
</tr>
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<tbody>
<tr>
<td><strong>Set up the conversation</strong></td>
<td>“I’m hoping we can talk about where things are with your illness and where they might be going — is this okay?”</td>
</tr>
<tr>
<td>1. Set up the conversation</td>
<td>“What is your understanding now of where you are with your illness?”</td>
</tr>
<tr>
<td></td>
<td>“How much information about what is likely to be ahead with your illness would you like from me?”</td>
</tr>
</tbody>
</table>
| 2. Assess illness understanding and information preferences | Prognosis: “I’m worried that time may be short.”  
|  | or “This may be as strong as you feel.” |
| 3. Share prognosis | “What are your most important goals if your health situation worsens?” |
|  | “What are your biggest fears and worries about the future with your health?” |
|  | “What gives you strength as you think about the future with your illness?” |
| 4. Explore key topics | “What abilities are so critical to your life that you can’t imagine living without them?” |
|  | “If you become sicker, how much are you willing to go through for the possibility of gaining more time?” |
|  | “How much does your family know about your priorities and wishes?” |
| 5. Close the conversation | “It sounds like _________ is very important to you.” |
|  | “Given your goals and priorities and what we know about your illness at this stage, I recommend…” |
| 6. Document your conversation | “We’re in this together.” |

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Serious Illness Conversation
Documentation...

- Date of Conversation
- Participants
- Pt /family understanding of illness
- Pt / family preferences regarding information
  ( big picture vs details, for example )
- Prognosis shared with Pt / family
- Pt’s and/or family’s goals
- Pt’s and/or family’s biggest fears and worries
Serious Illness Conversation

Documentation

- Pt’s and/or family’s sources of strength
- Pt’s abilities, capabilities or qualities that are so critical that the patient could not imagine life without them
- What the patient is willing to go through for the possibility of gaining more time
- What the family knows about the patient’s priorities and wishes
- Recommendations in light of goals, priorities and prognosis
Emergency Response Wishes

Name: ___________________________ Date of Birth: ____________

☐ I want all attempts of resuscitation to be considered in an emergency situation. (Initials: ____)
☐ I want CPR if my heart stops. (Initials: _____)  DNR
☐ I want intubation for breathing assistance. (Initials: _____)  DNI

I generally wish to decline any medical treatment that does not provide reasonable benefit to my current condition and wish to allow a natural death (A-N-D).

☐ I do not want CPR if my heart stops. (Initials: _____)  DNR
☐ I do not want to be intubated for breathing assistance. (Initials: _____)  DNI

The person I appoint to decide my health care treatment if I become unable to make my own decisions (Medical Durable Power of Attorney or MDPOA) is:

Name: ___________________________ Phone#: ______________________

If that person is unreachable, I appoint:

Name: ___________________________ Phone#: ______________________

Your Signature: ___________________________ Date: ____________

Power of Attorney if appointed: ___________________________ Date: ____________

Witness #1 (optional): ___________________________ Date: ____________

Witness #2 (optional): ___________________________ Date: ____________

(The witnesses should not be a health care provider OR health care employee or a family member or expected beneficiary)

Recommendations:

- Discuss these wishes with your close family members and those persons you will ask to make medical decisions if you are unable to do so.
- Take to your primary physician to sign and upload into Quality Health Network (QHN), the regional health information exchange. Providers note: Instructions for uploading this form are available under the Resources tab, QHN System Tip Sheets, at: www.qualityhealthnetwork.org.
- Keep this in a “butterfly folder” on your refrigerator. This folder is used to notify emergency personnel of your wishes, and may be taken with you if you are admitted to the hospital.
- Complete a Medical Durable Power of Attorney (MDPOA) wallet card with this information. Cards are available at www.hopewestco.org or at your doctor’s office.

Provider Signature (optional) ___________________________ Date: ____________

NOTE: If patient is in Nursing Home, Assisted Living or Hospital the M.O.S.T. form should be completed.

This form was designed and approved by the Mesa County ACP Project Team 11/2016. Contact Hopewest at 970-257-2360 for more information.
Flagging of Patients

If an ACP Document Type is associated with the patient the ACP flag will display.
Click on **Patient Documents**
Advance Care Planning Billing Codes

- 99497 first 30 mins
- 99498 each additional 30 mins
- Can include but does not require completion of forms
- Can include but does not require participation or presence of patient face-to-face
Wrap-up, Summary and Questions

- Wrap-up
- Summary
- Questions from the conference participants