Conversations of a Lifetime®

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Conversations of a Lifetime®.org

A multifaceted improvement strategy aimed at moving the ACP process upstream of a crisis or end-of-life circumstance.

Advance Care Planning Facilitator Training

Physician/Provider Coaching

TriHealth EMR Enhancements

Technical Support

Objectives

1. Identify tools to assist with the advance care planning process

1. Identify 2 communication skills to facilitate patient centered advance care planning conversations

What is Advance Care Planning?

- A series of conversations to discuss and understand a patients wishes for end-of-life care.
- Documenting wishes to provide a shared understanding of what matters most, including advance directives.
- A roadmap for health care professionals in the event the patient is no longer able to speak for themselves.

It’s about the conversation

We plan for weddings, the birth of a child, going off to college, and retirement. Despite the conversations we have for these life events, rarely do we have conversations about how we want to be care for at the end of our lives.

Talking about end-of-life

Experience. Compassionate. Caring.℠

We've Had the Conversation. **Have You?**

start your conversation today »

CONSIDER THE FACTS

90% of people say that talking with their loved ones about end-of-life care is important.

but

27% have actually done so.

Source: The Conversation Project National Survey 2013.

Talking to our doctors

Experience. Compassionate. Caring.℠

We've Had the Conversation. **Have You?**

start your conversation today »

CONSIDER THE FACTS

80% of people say that if seriously ill, they would want to talk to their doctor about end-of-life care.

but

7% report having had an end-of-life conversation with their doctor.

Source: Survey of Californians by the California HealthCare Foundation (2012)

Writing it down

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We've Had the Conversation. **Have You?**

start your conversation today »

CONSIDER THE FACTS

82% of people say it's important to put their wishes in writing.

but

23% have actually done it.

Source: Survey of Californians by the California HealthCare Foundation (2012)

Advance Care Planning as part of overall wellness

- It's important to have these conversations, no matter their health status. Anyone can have an accident regardless of his or her health.
- It is important for you to consider what decisions you would make if you were unable to speak for yourself due to injuries or a serious illness
- It is important for your family and healthcare team to understand what you want.

How often should we have an advance care planning conversation/update your advance directives?

Through the Developmental Stages of Life	
At 16	Accidents happen. Provides direction to your parents or legal guardians
College	You are on your own for the first time and your parents or NOK are often far away
Married	Your NOK changes from parents or guardian to your spouse
First Child	Name guardianship if something were to happen to you
Retirement	Goals for retirement also includes planning for the unexpected to happen
The 5 Ds	
Death	Death of a friend or family member can be used as a catalyst for a meaningful discussion
Divorce	Choose another proxy and redo directives
Diagnosis	Dx of a significant medical condition, a chronic or terminal illness
Decade	It's been 10 years since the last talk or review of documents
Decline	In physical or mental condition

Stages of Advance Care Planning

- All Healthy Adults
  - Name a healthcare power of attorney
- Adults living with a chronic illness
  - Understand their illness, potential complications, and what treatment decisions will need to be made in the future
- Adults who are in their last 1- 2years of life
  - May be experiencing the complications; and discuss goals of care

Advance Directives

- A general term
- Gives instructions about future care if you are unable to participate in medical decisions due to serious illness or incapacity

Living Will

Medical/Healthcare POA

Being a good medical proxy

Tool #7

The Proxy Quiz for Family or Physician

How well does your family, proxy, or doctor know your health care wishes? This short test can give you some sense of how well you have communicated your wishes to them. Consider this a tool to promote better conversation and understanding.

INSTRUCTIONS:

Step 1:
Answer the 10 questions using the **Personal Medical Preferences** test which follows.

Step 2:
Then, ask your health care proxy, family member, or close friend to complete **the Proxy Understanding of Your Personal Medical Preferences** test. The questions are the same. Don't reveal your answers until after they take the test. They should answer the questions in the way they think *you* would answer. (Try the same test with your doctor, too.)

Step 3:
GRADING – Count one point for each question on which you and your proxy (or you and your doctor) gave the ***same*** answer. Their proxy score is rated as follows:

Points	Grade	
10	*Superior*	… You are doing a great job communicating!
8 – 9	*Good*	… Need some fine tuning!
6 – 7	*Fair*	… More discussion needed.
5 or below	*Poor*	… You have a lot of talking to do!

DNR COMFORT CARE

DNR ORDER FORM

A printed copy of this order form or other authorized DNR identification must accompany the patient during transports and transfers between facilities.

Patient Name:	Patient Birth Date:
Optional Patient or Authorized Representatives Signature	
Printed name of Physician, APRN or PA*	Date
REQUIRED Signature of Physician, APRN or PA	Phone
REQUIRED for APRN or PA: Name of the supervising physician (PA) or collaborating physician (APRN) for this patient and the physician's NPI, DEA or Ohio medical license number.	

CHECK ONLY ONE BOX BELOW

☐ **DNR Comfort Care — Arrest:** Providers will treat patient as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions will cease and the DNR Comfort Care protocol will implemented.

☐ **DNR Comfort Care:** The following DNR protocol is effective immediately.

DNR PROTOCOL

Providers Will:	**Providers Will Not:**
• Conduct an initial assessment • Perform Basic Medical Care • Clear airway of obstruction or suction • If necessary for comfort or to relieve distress, may administer oxygen, CPAP or BiPAP • If necessary, may obtain IV access for hydration or pain medication to relieve discomfort, but not to prolong death • If possible, may contact other appropriate health care providers (hospice, home health, physician, APRN or PA)	• Perform CPR • Administer resuscitation medications with the intent of restarting the heart or breathing • Insert an airway adjunct • De-fibrillate, cardiovert or initiate pacing • Initiate continuous cardiac monitoring

Physicians, emergency medical services personnel, and persons acting under the direction of or with the authorization of a physician, APRN or PA who participate in the withholding or withdrawal of CPR from the person possessing the DNR identification are provided **immunities under section 2133.22 of the Revised Code.** This DNR order is effective until revoked and may not be altered. Any medical orders, instructions or information other than those required elements of the form itself, that are written on this order form are not transportable and are not provided protections or immunities.

* A DNR may be issued by an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) when authorized by section 2133.211 of the Ohio Revised Code.

HEA 1930 Revised 03/2019

MOLST in OHIO

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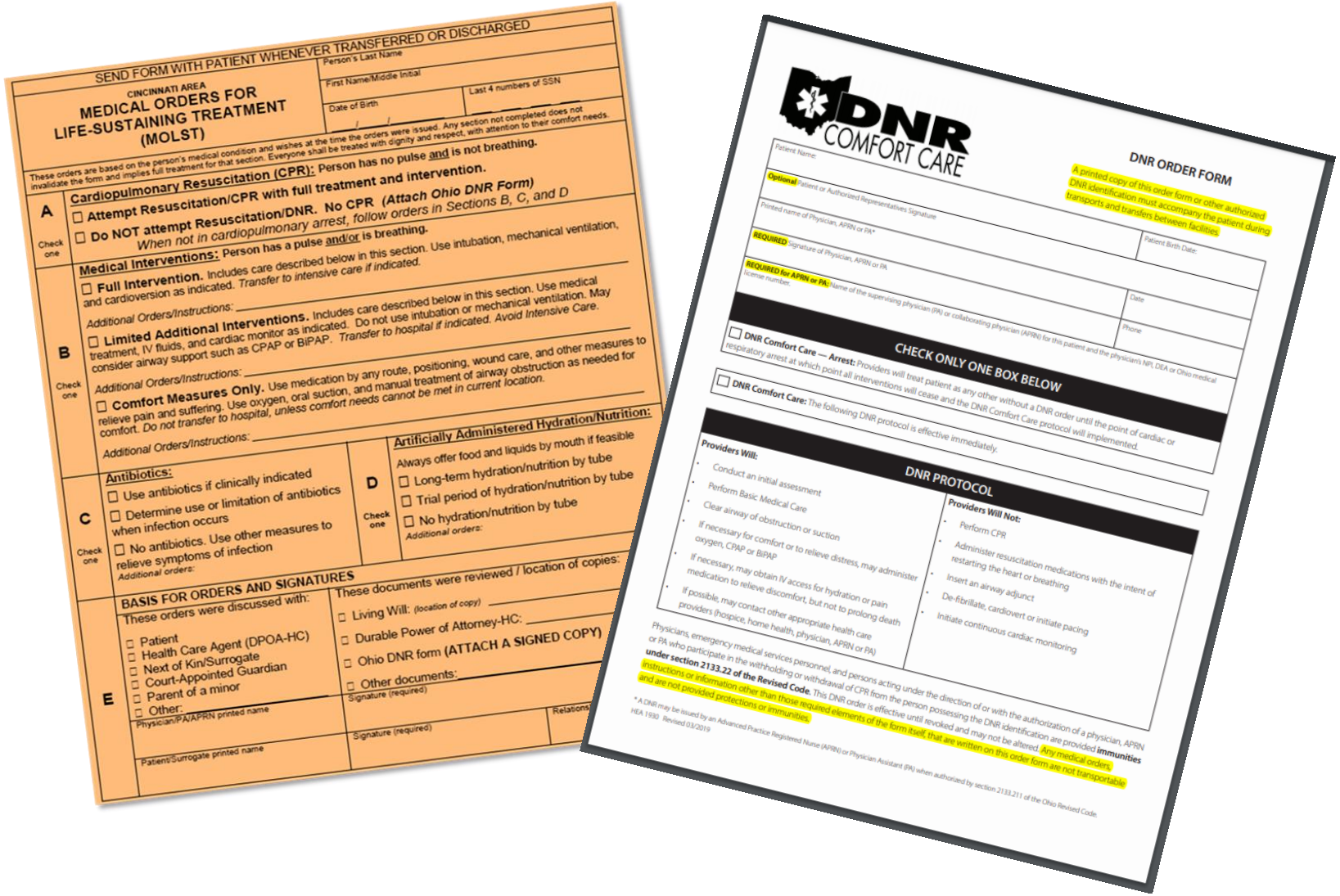

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

CINCINNATI AREA
MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST)

Person's Last Name | First Name/Middle Initial | Date of Birth | Last 4 numbers of SSN

These orders are based on the person's medical condition and wishes at the time the orders were issued. Any section not completed does not invalidate the form and implies full treatment for that section. Everyone shall be treated with dignity and respect, with attention to their comfort needs.

A Check one

Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing.

☐ **Attempt Resuscitation/CPR with full treatment and intervention.**

☐ **Do NOT attempt Resuscitation/DNR. No CPR** *(Attach Ohio DNR Form)*
When not in cardiopulmonary arrest, follow orders in Sections B, C, and D

B Check one

Medical Interventions: Person has a pulse and/or is breathing.

☐ **Full Intervention.** Includes care described below in this section. Use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to intensive care if indicated.*

Additional Orders/Instructions:

☐ **Limited Additional Interventions.** Includes care described below in this section. Use medical treatment, IV fluids, and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May consider airway support such as CPAP or BiPAP. *Transfer to hospital if indicated. Avoid Intensive Care.*

Additional Orders/Instructions:

☐ **Comfort Measures Only.** Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital, unless comfort needs cannot be met in current location.*

Additional Orders/Instructions:

C Check one

Antibiotics:

☐ Use antibiotics if clinically indicated
☐ Determine use or limitation of antibiotics when infection occurs
☐ No antibiotics. Use other measures to relieve symptoms of infection

Additional orders:

D Check one

Artificially Administered Hydration/Nutrition:

Always offer food and liquids by mouth if feasible
☐ Long-term hydration/nutrition by tube
☐ Trial period of hydration/nutrition by tube
☐ No hydration/nutrition by tube

Additional orders:

E

BASIS FOR ORDERS AND SIGNATURES

These orders were discussed with:
☐ Patient
☐ Health Care Agent (DPOA-HC)
☐ Next of Kin/Surrogate
☐ Court-Appointed Guardian
☐ Parent of a minor
☐ Other:

These documents were reviewed / location of copies:
☐ Living Will: *(location of copy)*
☐ Durable Power of Attorney-HC:
☐ Ohio DNR form **(ATTACH A SIGNED COPY)**
☐ Other documents:

Physician/PA/APRN printed name | Signature (required) | Relations

Patient/Surrogate printed name | Signature (required)

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Optional Patient or Authorized Representatives Signature

Printed name of Physician, APRN or PA*

Patient Birth Date:

REQUIRED Signature of Physician, APRN or PA

REQUIRED for APRN or PA: Name of the supervising physician (PA) or collaborating physician (APRN) for this patient and the physician's NPI, DEA or Ohio medical license number:

Date

Phone

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HEA 1930 Revised 03/2019

MOLST

- Section A – CPR
  - Selections made for Code Status
- Section B – Medical Interventions
  - Selections made between the below:
    - Full Interventions
    - Limited/Selective Interventions
    - Comfort Measures Only
- Section C & D – Antibiotics/Artificial Nutrition

MOLST

Medical Orders for Life Sustaining Treatment	
What is it?	A very specific set of medical orders documenting the patient's wishes for end-of-life care and treatment. The MOLST form is signed by the MD, PA or APRN and honored by the care team.
Who is it for?	Patients with serious chronic illness, the terminally ill or the frail elderly.
What does it do?	Documents the patient's expressed goals for care and preference for treatment.
What are the steps?	A series of conversations with the patient, family and/or health care agent (proxy, HCPOA, surrogate) that includes goal discovery through shared decision making about care preferences at the end-of-life.
The MOLST form MUST accompany the OHIO DNR if the patient prefers no rescusitation.	

"Would I be surprised if this patient died in the next year or so?"

Where should all this information be kept?

- A spouse, partner, children, parent, siblings
- Close friend
- Your doctor and other health care providers
- Your pastor, priest, rabbi, etc
- Your attorney
- In a clearly marked file
- DNR/MOLST- on the refrigerator , clearly marked

Importance of the conversation

Information gathering

- Who can you gather information from?
  - The individual
  - Facility Staff
  - Caregivers
  - Doctor/ Nurse
  - Family
  - Prior Documentation (HCPOA, Living Will, etc)

Information gathering

- **What information is important to gather?**
  - What activities bring the person joy?
  - Has the individual been to the hospital recently?
    - How many times?
  - What medical conditions does the individual have and do you understand these conditions?
  - What are the benefits and risks of treatment?

Values worksheet

How important to you are the following items?	VERY IMPORTANT		→		NOT IMPORTANT
Letting nature take its course	4	3	2	1	0
Preserving my quality of life	4	3	2	1	0
Staying true to my spiritual beliefs and traditions	4	3	2	1	0
Living as long as possible, regardless of quality of life	4	3	2	1	0
Being independent	4	3	2	1	0
Being comfortable and as pain-free as possible	4	3	2	1	0
Leaving good memories for family and friends	4	3	2	1	0
Making a contribution to medical research or teaching	4	3	2	1	0
Being able to relate to family and friends	4	3	2	1	0
Being free of physical limitations	4	3	2	1	0
Being mentally alert and competent	4	3	2	1	0
Being able to leave money to family, friends, charity	4	3	2	1	0
Dying in a short time rather than lingering	4	3	2	1	0
Avoiding expensive care	4	3	2	1	0

Standards

Substituted Judgment

- Substituted Judgment is the principle of decision-making that substitutes the decision the person would have made when the person had capacity as the guiding force in any surrogate decision the guardian makes.
- Substituted Judgment is not used when following the person's wishes would cause substantial harm to the person or when the guardian cannot establish the person's goals and preferences even with support.

Best Interest

- Best Interest is the principle of decision-making that should be used only when the person has never had capacity, when the person's goals and preferences cannot be ascertained even with support, or when following the person's wishes would cause substantial harm to the person.
- The Best Interest principle requires the guardian to consider the least intrusive, most normalizing, and least restrictive course of action possible to provide for the needs of the person.
- The Best Interest principle requires the guardian to consider past practice and evaluate reliable evidence of likely choices.

Decision Making - Priorities for Medical Treatment

- **Full Treatment**
  - Live as long as possible – receive all care doctors believe will help (Ex. Intensive Care (ICU), machines for breathing, etc)
- **Selective Treatment**
  - Live longer, if quality of life and comfort can be achieved
  - Be in the hospital as needed for treatment
  - Stop treatment that does not work or makes me feel worse
- **Comfort Treatment**
  - Live the rest of my life focusing on my comfort and quality of life
  - Avoid the hospital unless needed for comfort

Example

Should we use a breathing machine or oxygen?

- What are your priorities for the patient?
- What is the goal for this therapy or treatment?
- What is the medical team telling your about this treatment?

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Learn How To Talk About End of Life.

Things You Shouldn't Wait To Say

Click here to see our grassroots community engagement campaign to begin advanced care planning conversations.

Start the Conversation

Click here for answers to basic questions, some great tips and and an easy starter kit.

Resources for Taking Action

Click here to find tools, worksheets, state forms, MOLST and video clips.

End of Life Care

Click here to learn if hospice care is right for you or your family.

Questions?
Contact Us

Info For Providers | TriHealth | Bethesda Inc. | Hospice of Cincinnati — Experience. Compassionate. Caring.℠ | Catholic Health Initiatives® | Media Kit

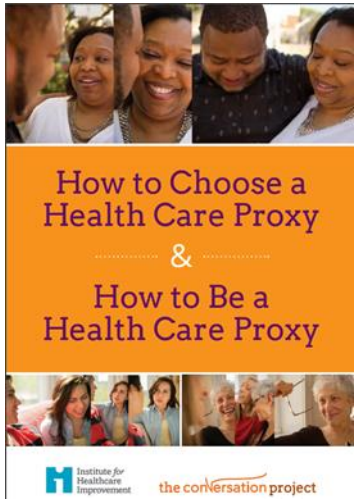
Resources

- "What is Advance Care Planning" –one page handout with basic information

- Starter kits
  - How to Choose a Health Care Proxy & How to Be a Health Care Proxy
  - Your Conversation Starter Kit (available in several languages)
  - Your Conversation Starter Kit – For Families and Loved Ones of People with Alzheimer's Disease or Other Forms of Dementia

- Copies of Advance Directives
  - Ohio's Living Will
  - Ohio'sHealth Care Power of Attorney
- Note: link to other states documents available on our website

- Conversations of a Lifetime Website cards



Thank you!

Questions? Contact me at Kelly_Haley@trihealth.com