KHC Webinar

March 24, 2021

Advance Care Planning III

In Partnership with

Health Quality Innovation Network

Center for Practical Bioethics
Guidance at the Crossroads of Decision

kfmc Health Improvement Partners

Kansas Medical Society Established 1859

Kansas Healthcare Collaborative

Kansas Hospital Association

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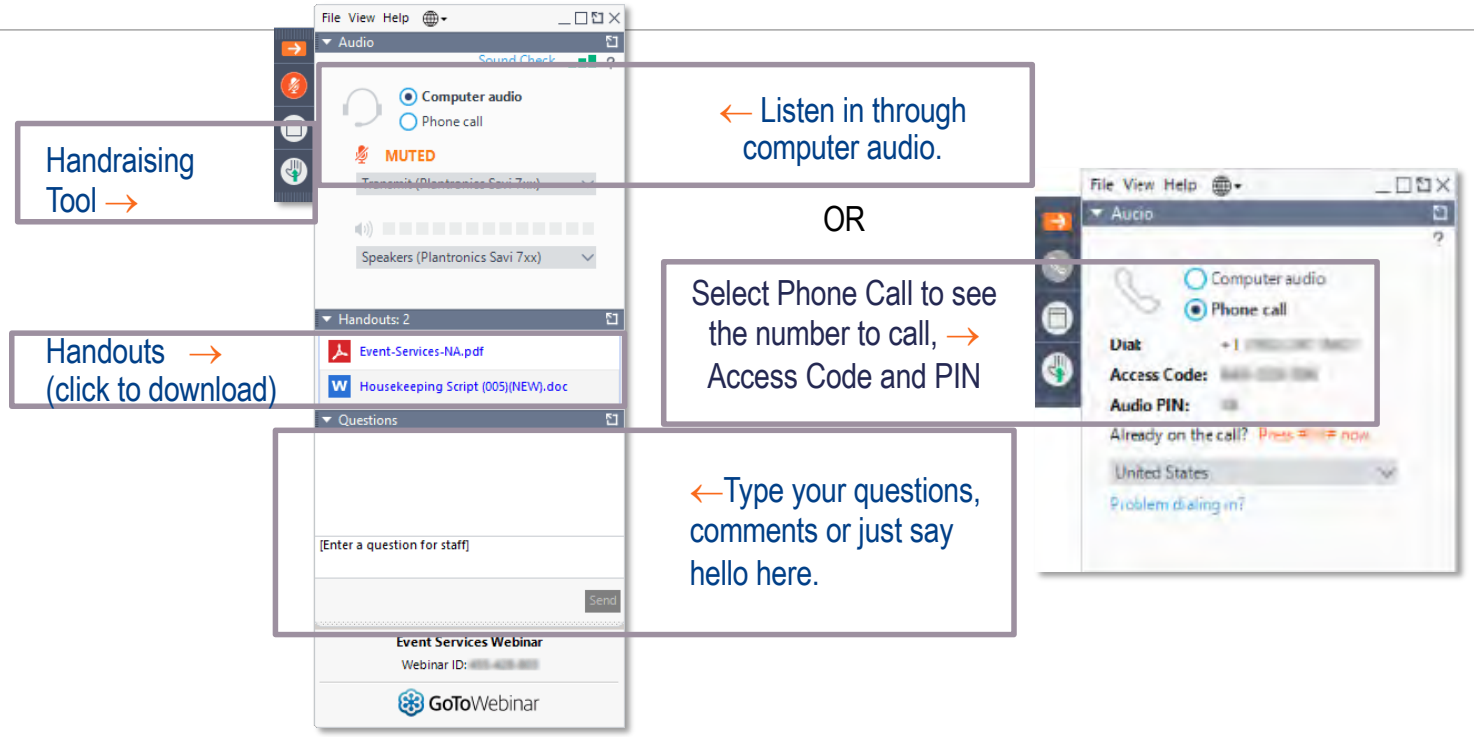
Attendee Control Panel



Thank you to our Kansas-Missouri HQIN contacts for their role in planning today's event.

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HQIN
Health Quality Innovation Network

Opportunity to receive Nursing CE for attending today's live event

Greater Kansas City Chapter of the American Society for Pain Management Nursing is approved as a provider of continuing nursing education by the Kansas State Board of Nursing. This course offering is approved for 1.3 contact hours applicable for RN, LPN, or LMHT relicensure. Kansas State Board of Nursing Provider Number: LT LT0279-0412.

Complete the online evaluation at the conclusion of today's event.

Continuing education for nursing is available only to those participating in the live event on March 24, 2021, and who complete the online evaluation (link provided at end of today's presentation) no later than March 29, 2021.

CENTER FOR PRACTICAL BIOETHICS
GUIDANCE AT THE CROSSROADS OF DECISION

TPOPP
KANSAS-MISSOURI
Transportable Physician Orders for Patient Preferences
A POLST Paradigm Program

Advance Care Planning & Medical Orders

MARCH 24, 2021

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Participants may be asked to consider donations.

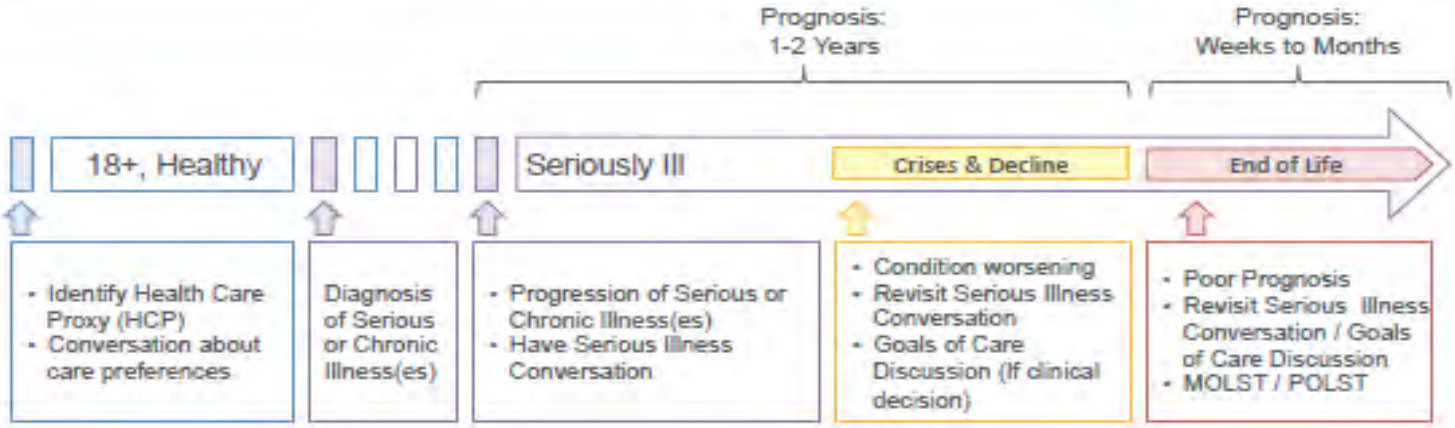
ACP Webinar Series – Three sessions

ACP - 101	ACP -201	ACP and Medical Orders
Purpose and process of ACP. Emphasis on normalizing & encouraging attendees to complete own. 2 types: DPOAHC and HC Directive and duties of declarant and agent. Relevant state laws governing execution	Principles guiding clinicians in carrying out advance care plans. Details difference between capacity and competency, shared decision-making, substituted judgement, and best interest principles.	Role of standardized medical order sets in relation to ACP. Addresses advanced illness medical order sets (POLST) and “accelerated” ACP for use in health crisis or pandemics.

Objectives - Session 3

Differentiate	Identify	Improve
… medical orders from advance directives	… resources and tools for clinicians in facilitating accelerated ACP	… the role of the clinician as capacity diminishes

Advance Care Planning Terminology



Advance Care Planning = Planning in Advance of Serious Illness

Serious Illness Care Conversation = Planning in the context of progression of serious illness

Goals of Care Discussion = Decision making in context of clinical progression / crisis / poor prognosis

DANA-FARBER CANCER INSTITUTE

Goals for Advance Care Planning

- Map out plans for future care
- Best before a crisis
- Encourage conversations with family and loved ones.
- Clarify diagnosis, prognosis and life expectancy
- Educate
- Identify individual's values - explore using lay language, not clinical

Components of Goals of Care Discussion

Introductions

Take the emotional pulse/empathize

- Emotional will not be able to listen to the cognitive

Clarify the purpose of the meeting

- Define why everyone is meeting
- Discuss why this meeting is important
- Include that this is about the planning for future medical care.

Clarify and Conclude

Don’t force a decision

Start with the basics: DNR, feeding tubes

Restate “ as I understand you, it sounds like you want___ and do not want ___. Is that correct?

Based on my understanding of your values and goals and what I think is best, my plan will be to _____. Is that OK?

We know who they are: Identifying Seriously Ill population

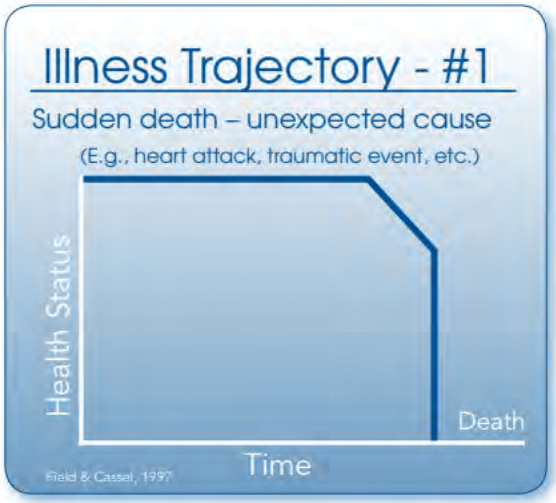
FIGURE 9: **Three Key Variables to Identify the Population in Need**

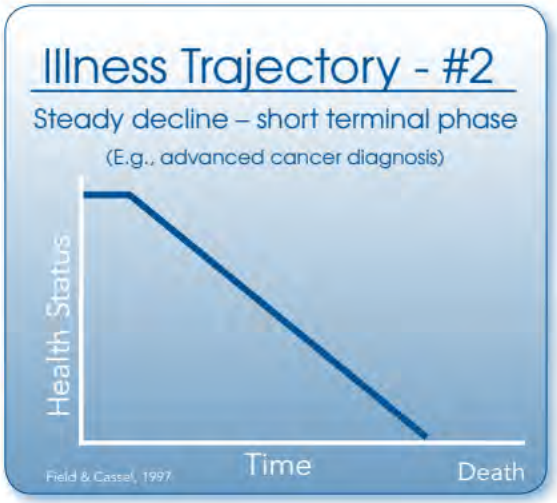
CAPC: Serious Illness Strategies for Health Plans and Accountable Care Organizations, 2017

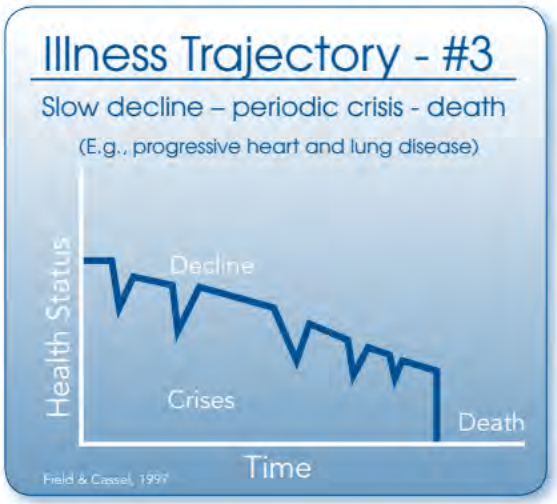
Assessing life expectancy

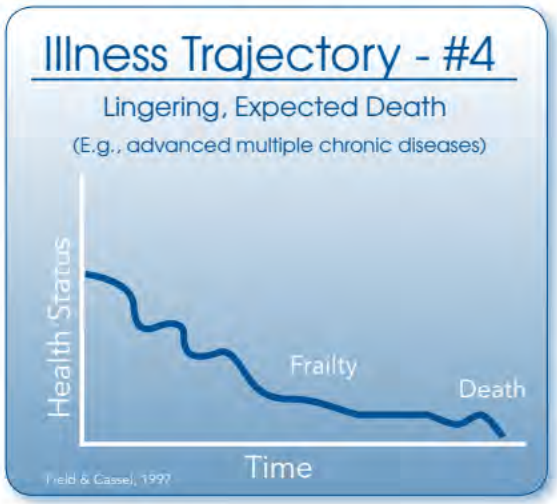
- Functional predictors: impairment in ADL
- Cognitive predictors: moderate to severe dementia
- Nutritional predictors: weight loss, fluid accumulation, sarcopenia
- Patients self-report
- Critical Illness in patients with moderate to severe debility=high mortality.

Functional Trajectories









* Adapted from Field, M. J. & Cassel, C. K. (Ed.). (1997) ***Approaching Death: Improving care at the end of life.*** Division of Health Care Services. Institute of Medicine. Washington D.C.: National Academy Press.

Debility and Critical Illness

More than half died within 1 month or experienced significant functional decline over the following year with poor outcomes in those who had high levels of pre-morbid disability.

Does decisions for ICU make sense when we know the outcome is the same?

Ferrante et al: studied functional trajectories in older adults both prospectively and following admission to an ICU

Medical Order Sets and POLST

Use as a guide or outline for conversation

Code Status

- yes / no…and more

Degree of Medical Interventions

- Full, Selected and Comfort (always)

Additional Orders

Nutrition

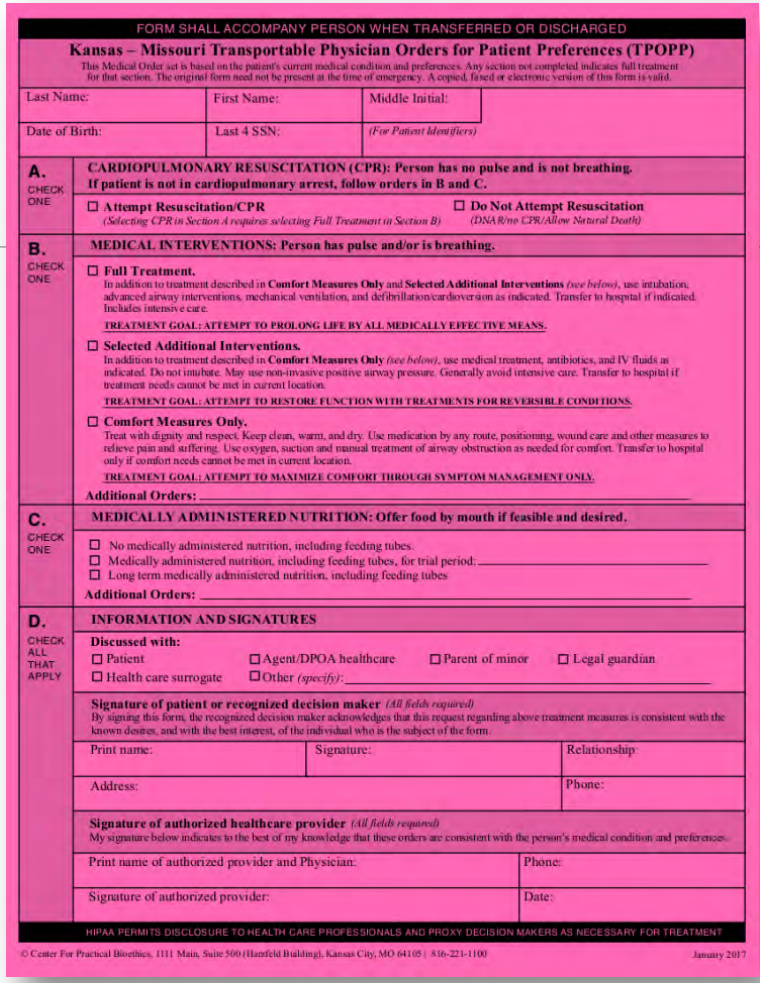
What is POLST/TPOPP?

Transportable Physician Orders for Patient Preferences/Physician Orders for Life Sustaining Treatment

A uniform order set for seriously ill and medically frail patients

- Section A: Cardiopulmonary Resuscitation
- Section B: Medical Interventions
- Section C: Medically Administered Nutrition

Designed to transport with the patient across care settings



FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Kansas – Missouri Transportable Physician Orders for Patient Preferences (TPOPP)

This Medical Order set is based on the patient's current medical condition and preferences. Any section not completed indicates full treatment for that section. The original form need not be present at the time of emergency. A copied, faxed or electronic version of this form is valid.

Last Name: | First Name: | Middle Initial:

Date of Birth: | Last 4 SSN: | *(For Patient Identifiers)*

A. CHECK ONE — **CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing. If patient is not in cardiopulmonary arrest, follow orders in B and C.**

☐ **Attempt Resuscitation/CPR** *(Selecting CPR in Section A requires selecting Full Treatment in Section B)*

☐ **Do Not Attempt Resuscitation** *(DNAR/no CPR/Allow Natural Death)*

B. CHECK ONE — **MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.**

☐ **Full Treatment.**
In addition to treatment described in **Comfort Measures Only** and **Selected Additional Interventions** *(see below)*, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.
TREATMENT GOAL: ATTEMPT TO PROLONG LIFE BY ALL MEDICALLY EFFECTIVE MEANS.

☐ **Selected Additional Interventions.**
In addition to treatment described in **Comfort Measures Only** *(see below)*, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.
TREATMENT GOAL: ATTEMPT TO RESTORE FUNCTION WITH TREATMENTS FOR REVERSIBLE CONDITIONS.

☐ **Comfort Measures Only.**
Treat with dignity and respect. Keep clean, warm, and dry. Use 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 to hospital only if comfort needs cannot be met in current location.
TREATMENT GOAL: ATTEMPT TO MAXIMIZE COMFORT THROUGH SYMPTOM MANAGEMENT ONLY.

Additional Orders: _____

C. CHECK ONE — **MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.**

☐ No medically administered nutrition, including feeding tubes.
☐ Medically administered nutrition, including feeding tubes, for trial period: _____
☐ Long term medically administered nutrition, including feeding tubes

Additional Orders: _____

D. CHECK ALL THAT APPLY — **INFORMATION AND SIGNATURES**

Discussed with:
☐ Patient ☐ Agent/DPOA healthcare ☐ Parent of minor ☐ Legal guardian
☐ Health care surrogate ☐ Other *(specify)*: _____

Signature of patient or recognized decision maker *(All fields required)*
By signing this form, the recognized decision maker acknowledges that this request regarding above treatment measures is consistent with the known desires, and with the best interest, of the individual who is the subject of the form.

Print name: | Signature: | Relationship:

Address: | Phone:

Signature of authorized healthcare provider *(All fields required)*
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print name of authorized provider and Physician: | Phone:

Signature of authorized provider: | Date:

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

 January 2017

Advance Directive vs. TPOPP/POLST

Advance Directive: "Living Will" health care directive and agent appt.	TPOPP/POLST
Initiated by adult individual (majority age) to name person to speak for them when no longer capable and to state values and treatment preferences. Directives are statements by individuals (witnessed or notarized)	Initiated by healthcare authorized healthcare provider to execute medical order set designed for those with chronic progressive illness or frailty Medical orders or executed by medical providers
Complete for future	Applies to person's current situation. Medical orders for now.
Becomes effective when decision-making capacity is lost	Not conditional on decision- making capacity
May not be available in all settings	Accompanies patient across settings

Evidence for aggressive rescue measures

CPR

- Survival rate about 17% in-hospital.
- Survival rate 7.5% outside hospital (community setting)
- Of those who survive CPR in long term care >99% die within 120 days.

Mechanical Ventilation

- short term effective, long term - high morbidity and mortality.

Evidence for aggressive rescue measures

2019 JAGS Study on OHDNR CPR attempts in Adults >80

- Death rate prior to discharge for “appropriate” group 97%
- 99.4% for “uncertain” group, and 97.9% for “inappropriate” group
- Mortality rate prior to discharge for nursing home residents 100%.(107/590)

Cardiopulmonary Resuscitation in Adults Over 80: Outcomes and the Perception of Appropriateness by Clinicians, P Druwe, et.al., JAGS 00:1-7, 2019.

Evidence

As a rule, tube feedings do not prolong life and may cause more complications.

Withholding artificial nutrition is neither painful nor uncomfortable. People adapt physiologically to decreases intake of food and fluid

Dehydration has a sedating effect.

IV Hydration-at EOL can increase suffering, (fluid accumulation in tissues and increased secretions).

Antibiotics can cause complications and may not be palliative.

- Pneumonia can be managed through comfort measures

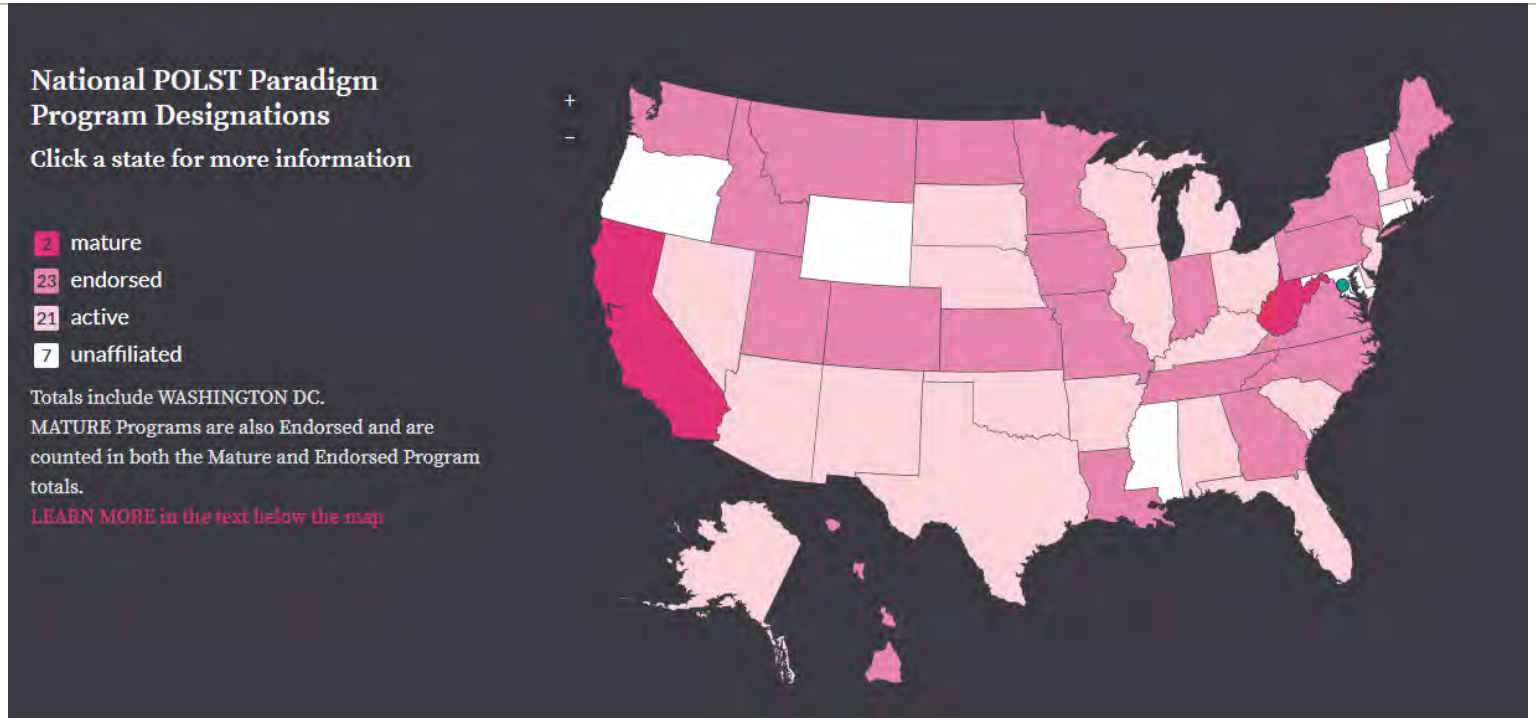
Ethics during a crisis (pandemic or CSC)

- Hospitals and physicians will need to balance individual needs of each patient and larger needs of community.
- Decision to not institute aggressive rescue treatment is ethically allowable as is withdrawal of treatment when it does not achieve goal
- Emotionally difficult for families to withdrawal treatment
- The fact that we are facing a crisis is an ethical lesson.
- Allowing for a natural death.

Goals of Care discussions Accelerated ACP and Medical Order Sets

RESOURCES

POLST Programs Nationwide



Accessed on 10/08/19 at http://polst.org/programs-in-your-state/

Resources and Tools: Types and Kinds

ACP Discussion guides and prompts (designed for consumers)	Decision Aids about particular treatment preferences	Provider Facilitated discussions to clarify goals of care
Medical Orders and specific instructions	Documentation/Recording mechanisms (MyDirectives®)	*Caring Conversations*® COVID-19 Tip Sheet

Clinical Guides

POLST/TPOPP Clinical Guides and Training materials (Videos, workshops, webinars, etc.)

Updated references to related clinical research

Incorporation of Ariadne Labs Serious Illness Care Planning conversation guide language

Available through
tpopp@practicalbioethics.org

Tools and Resources

CAPC COVID-19 RESPONSE RESOURCES

COVID READY COMMUNICATION FROM VITALTALK

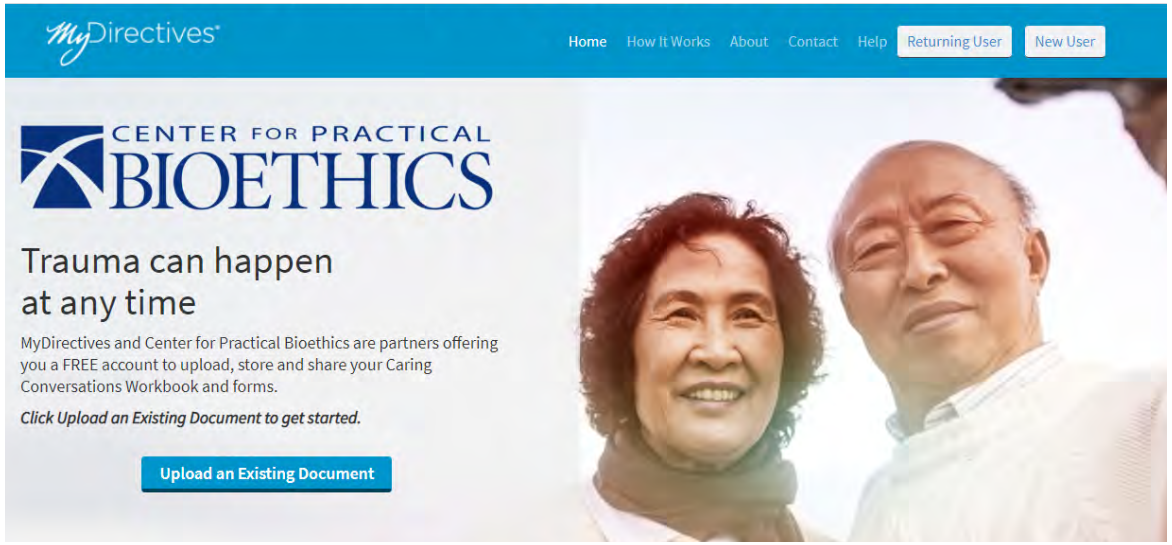
POLST AND COVID-19

WORKING WITH FAMILIES FACING UNDESIRED OUTCOMES (SWHPN)

Tools and Resources

A decision aid for patients considering life support at a time of COVID-19 Univ of CO

Caring Conversations



The following Tools and Resources are designed for use during times of **Crisis Standards**

Clinician Guides:

- Goals of Care Conversations and Decision Aids
- For distribution to participants

Clinician Guide: Goals of Care Conversation with Non-Medically Frail Individuals during times of crises

Version 1 - 4/1/2020. The University of Kansas Health System – Palliative Medicine. Phone: 913-588-3807, Email: palliativecare@kumc.edu. Adapted from: Serious Illness Conversation Guide developed by Ariadne Labs. The original content can be found at (www.ariadnelabs.org) and is licensed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License, http://creativecommons.org/licenses/by-nc-sa/4.0/Ariadne Labs licenses the original content as-is or as available, and makes no representations or warranties of any kind concerning the original content or concerning this material, which Ariadne Labs has not reviewed or endorsed.

CONVERSATION STRUCTURE	SAMPLE LANGUAGE
Set up conversation.	"I'm very sorry that you have COVID-19. I want to talk to you about how you are feeling."
Assess understanding. Provide education. Identify preferences.	"Tell me what you know about how COVID-19 can affect individuals even when they are healthy." "You are right/Well actually, COVID-19 is a viral illness. There is not a known cure. It can be a mild flu-like illness with fever, sore throat, cough, and muscle soreness. However, some people need to be in the hospital to get oxygen and other medicines. While this is all most healthy people need, we know that even healthy people can get critically ill and develop respiratory failure where you are not able to breathe on your own. If this happens to you, this means going to the ICU. You would have a tube is put in your mouth, down your throat, and into your windpipe. This tube is connected to a breathing machine called a ventilator. The hope would be the ventilator can support your lungs while giving your body time to recover from COVID-19. Would you be okay with this? If yes, proceed to next box. If no, rephrase "If you develop respiratory failure and choose not to go on a ventilator, you will pass away. We would give you medicines and oxygen to keep you from suffering, but you would die. When you hear this, tell me more about your thoughts."
Identify health care surrogate.	"Tell me who is the person you want the doctors and nurses to communicate with and help make further decisions with us should you not be able to communicate." Get name and phone number of named surrogate. "It would be helpful to complete a form naming this person as a healthcare durable power of attorney (DPOA)." If they do have DPOA, ensure we have copy. If not and is agreeable to complete one, complete one with the patient.
Relay information to surrogate and document wishes.	"I'm going to call and let your surrogate know what we discussed. Is that okay? I'm also going to write it in your medical record, so all the doctors and nurses know what you want should you get sicker from COVID-19 which we all are very much hoping won't be the case."
Offer chaplain support.	"I know this time can be really scary. Our chaplains would like to call and provide support. May I ask a chaplain to call you?"

Clinician Guide: Goals of Care Conversation with Medically Frail Individuals during times of crises

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Conversation Structure	Sample Language
Set up conversation.	"I'm very sorry that you have COVID-19. I want to talk to you about how you are feeling."
Assess understanding. Provide education.	"Tell me what you know about how COVID-19 is affecting people like yourself that have other serious medical problems or are older." "You are right/Well actually, COVID-19 is a viral illness. There is not a known cure. We know it is particularly serious in patients like you. While it can be a mild flu-like illness with fever, sore throat, cough, and muscle soreness; it can be much more than this. I wish this weren't the case, but I worry you could get sick very quickly and may even be at risk of dying within a short period of time."
Identify preferences for hospitalization if in a community setting.	"There are some people who are ok being in the hospital and getting oxygen and other medicines to support them in the hopes that your body will be able to recover from the viral illness. Would you be okay with this?" If yes, proceed to next box. If no, reflect "I understand. We can always use medicines and oxygen to make sure you aren't uncomfortable. For most people, this will mean using hospice to make sure you aren't suffering."
Discuss medical recommendation about life support and code status. Clarify preferences.	"If you were to get a lot sicker from COVID-19 despite medicines and oxygen, there may come a time when you are not able to breathe on your own. If this happens, unfortunately this means that you will likely die from COVID-19. Going to the ICU and placing you on a life support machine called a ventilator or attempting CPR is very unlikely to help you at that point, so I would recommend not doing those things. What I would recommend is that we use medicines to ensure that you are comfortable and not suffering. Does that make sense?" If yes, proceed to next box. If no, reflect "I understand. There are some people who want to live as long as possible no matter what their life looks like. Is that how you feel?"
Identify health care surrogate.	"Tell me who is the person you want the doctors and nurses to communicate with and help make further decisions with us should you not be able to communicate." Get name and phone number of named surrogate. "It would be helpful to complete a form naming this person as a healthcare durable power of attorney (DPOA)." If they do have DPOA, ensure we have copy. If not and is agreeable to complete one, complete one with the patient.
Relay information to surrogate and document wishes.	"I'm going to call and let your surrogate know what we discussed. Is that okay? I'm also going to write it in your medical record, so all the doctors and nurses know what you want should you get sicker from COVID-19 which we all are very much hoping won't be the case."
Offer chaplain support.	"I know this time can be really scary. Our chaplains would like to call and provide support. May I ask a chaplain to call you?"

Clinician Guide: Goals of Care Conversation with Medically Frail persons during times of crises

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CONVERSATION STRUCTURE	SAMPLE LANGUAGE
Set up conversation.	"I'd like to check-in to see how you're doing during this stressful time of COVID-19. Is that ok?"
Assess understanding. Provide education.	"Tell me what you know about how COVID-19 is affecting people like yourself that have other serious medical problems or are older." "You are right/Well actually, COVID-19 is a viral illness. There is not a known cure. We know it is particularly serious in patients like you. While it can be a mild flu-like illness with fever, sore throat, cough, and muscle soreness; it can be much more than this. I wish this weren't the case, but I worry that if you contract this virus you could get sick very quickly and may even be at risk of dying within a short period of time."
Identify preferences for hospitalization if in a community setting.	"There are some people who develop COVID-19 and are ok being in the hospital and getting oxygen and other medicines to support them in the hopes that your body will be able to recover from the viral illness. Would you be okay with this?" If yes, proceed to next box. If no, reflect "I understand. If you develop COVID-19, we can always use medicines and oxygen to make sure you aren't uncomfortable. For most people, this will mean using hospice to make sure you aren't suffering."
Discuss medical recommendation about life support and code status. Clarify preferences.	"If you were to get a lot sicker from COVID-19 despite medicines and oxygen, there may come a time when you are not able to breathe on your own. If this happens, unfortunately this means that you will likely die from COVID-19. Going to the ICU and placing you on a life support machine called a ventilator or attempting CPR is very unlikely to help you at that point, so I would recommend not doing those things. What I would recommend is that we use medicines to ensure that you are comfortable and not suffering. Does that make sense?" If yes, proceed to next box. If no, reflect "I understand. There are some people who want to live as long as possible no matter what their life looks like. Is that how you feel?"
Identify health care surrogate.	"Tell me who is the person you want the doctors and nurses to communicate with and help make further decisions with us should you not be able to communicate." Get name and phone number of named surrogate. "It would be helpful to complete a form naming this person as a healthcare durable power of attorney (DPOA)." If they do have DPOA, ensure we have copy. If not and is agreeable to complete one, complete one with the patient.
Relay information to surrogate and document wishes.	"I'm going to call and let your surrogate know what we discussed. Is that okay? I'm also going to write it in your medical record, so all the doctors and nurses know what you want should you develop COVID-19 which we all are very much hoping won't be the case."
Offer chaplain support.	"I know this time can be really scary. Our chaplains would like to call and provide support. Would you like a chaplain to call you?"

Code Status Decision Aid during Crises

If your heart stops and you are not breathing, there are two options of medical care. We know that for individuals with COVID-19, the likelihood of surviving if your heart stops is extremely low. For most individuals who have other serious medical problems or are older, not attempting CPR is the right medical decision. For individuals that do not have other serious medical problems, attempting CPR might be the right option. Talk to your doctor about their recommendations. Talk to your loved ones about your wishes. **Below helps you walk through what each option means.**

What are your options?	Attempt CPR	Do Not Attempt CPR
What is it?	CPR is done by health care workers and includes: Pushing on your chest (chest compressions) Electric shocks and IV medicines If your heart restarts, a tube is put in your mouth, down your throat, and into your windpipe. This tube is connected to a breathing machine called a ventilator.	CPR is not provided.
What does it do?	Attempts to restart your heart and breathing.	Not providing CPR allows a natural death.
What are the benefits?	CPR may restart your heart and breathing.	Avoids machines.
What are the short-term burdens?	If CPR restarts your heart, you will need to be in the ICU. With the tube down your throat, you cannot speak or swallow. You may need medicine to keep you sedated. You may have pain or broken ribs from chest compressions. If CPR is not able to restart your heart and breathing, you will die.	You will die.
What are the long-term burdens?	You may not be able to get off the ventilator. You may have mild to severe brain damage. You may never be able to return home.	You will die.
Which option best fits with your values?	**Your Values**	**Your Values**
	You want the chance to live longer. You are willing to take the chance that your death may occur even with CPR. You are willing to have discomfort and be in the ICU. You are willing to take the chance that your death may be on machines. You accept that your death may be the result of coming off machines if the machines are not able to improve your condition.	You wish to allow a natural death. You do not want to be on machines at the hospital.

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Primary developers: Linda Briggs, MSN, MA, RN, and Sandra Schellinger, MSN, RN, NP-C
Funding and materials provided by Respecting Choices®, www.respectingchoices.org.
This product has been certified by the Washington State Health Care Authority pursuant to RCW 7.70.060. The date of certification is July 18, 2018, and will expire two years from this date, or sooner pursuant to Washington State policy. A full description of Washington's certification process, including required criteria is available at http://www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making.

Life Support Decision Aid during Crises

If you are not able to breathe on your own, there are two options of medical care. For some, going on a ventilator as a form of life support is the right decision. Others would not want to risk being on machines for end-of-life care. If you have other serious medical problems or are older, the likelihood of surviving this illness if you go on a ventilator is low. Talk to your doctor about their recommendations. Talk to your loved ones about your wishes. **Below helps you walk through what each option means.**

What are your options?	Ventilator/Life Support	Comfort Measures
What is it?	A tube is put in your mouth, down your throat, and into your windpipe. This tube is connected to a breathing machine called a ventilator.	Medicines and oxygen to lessen shortness of breath, pain, anxiety, and suffering to allow for a natural death.
What does it do?	Pushes oxygen into your lungs.	It helps with your symptoms. It does not treat your illness.
What are the benefits?	May allow you to recover. May allow you to live longer.	Avoids machines. Helps keep you comfortable as your body is passing away. For some people, this means you are able to be cared for at home by your loved ones and hospice.
What are the short-term burdens?	With the tube down your throat, you cannot speak or swallow. You may need medicine to keep you sedated. You will need to be in the ICU.	Medicines may make you feel drowsy.
What are the long-term burdens?	You may not be able to get off the ventilator. Your health may get worse, other problems may occur, and you may die.	You will die.
Which option best fits with your values?	**Your Values**	**Your Values**
	You want the chance to live longer. You are willing to have discomfort and be in the ICU. You are willing to take the chance that your death may be on machines. You accept that your death may be the result of coming off machines if the machines are not able to improve your condition.	You do not want to be on machines at the hospital. You wish to allow a natural death.

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Wrap Up

Thank you for joining us.

To receive a certificate of continuing nursing education (CNE) for attending this live event, complete the evaluation form at the link below no later than March 29.

www.KHConline.org/ACP3-evaluation