



Advance Care Planning: Having the Conversation

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ANMED HEALTH

Medical Crisis



In the Family Room:
“What would your loved one want?”



“We Never Talked about It!”

POTENTIALLY RESULTS IN ...

- Extreme Stress
- Family fighting
- Extended death
- Second-guessing and guilt

“DID I MAKE THE RIGHT CHOICE?”



Why is Advance Care Planning Necessary?

- System challenges in the hospital:
 - Hospitalists, not PCP
 - Specialists: the cardiologist, the nephrologist, the pulmonologist (silos)
 - Physician Time
 - Multidisciplinary Approach, no one “steering the ship”

Why is Advance Care Planning Necessary? (cont.)

- Distress of physician/anxiety about effect of bad news on patient/family
- Focus on symptom management, winning the daily battle with disease
- Timing

What is the Better Question?

"WHAT CAN WE DO?"



"WHAT **SHOULD** WE DO?"



Atul Gawande, Being Mortal: Medicine and What Matters in the End

“Being mortal is about the struggle to cope with the constraints of our biology, with the limits set by genes and cells and flesh and bone. Medical science has given us remarkable power to push against these limits, and the potential value of this power was a central reason I became a doctor. . . .

Atul Gawande, Being Mortal: Medicine and What Matters in the End

“But again and again, I have seen the damage we in medicine do when we fail to acknowledge that such power is finite and always will be. We’ve been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being. And well-being is about the reasons one wishes to be alive. Those reasons matter not just at the end of life, or when debility comes, but all along the way. . . .

Atul Gawande, Being Mortal: Medicine and What Matters in the End

“Whenever serious sickness or injury strikes and your body or mind breaks down, the vital questions are the same:

- What is your understanding of the situation and its potential outcomes?
- What are your fears and what are your hopes?
- What are the trade-offs you are willing to make and not willing to make?
- And what is the course of action that best serves this understanding?”

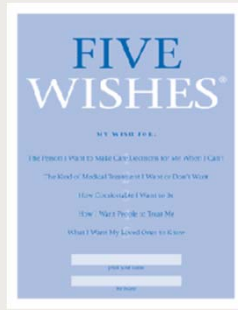
Foundational Belief of ACP Initiative

“For patients and their loved ones, no care decisions are more profound than those made near the end of life. . . . A person-centered, family-oriented approach that honors individual preferences and promotes quality of life through the end of life should be a national priority.”

Dying in America 2015 Institute of Medicine Report

Advance Care Planning Aids: Living Wills

FIVE WISHES



DNR



Advance Care Planning Aids: SC Health Care Power of Attorney (SCHCPOA)



- Free
- Easy to download from internet
- Brief
- Requires 2 witnesses, no notary

Decisions in the Form

- Choice of primary healthcare agent, first alternate, second alternate?
- Offer of tissues/organs?

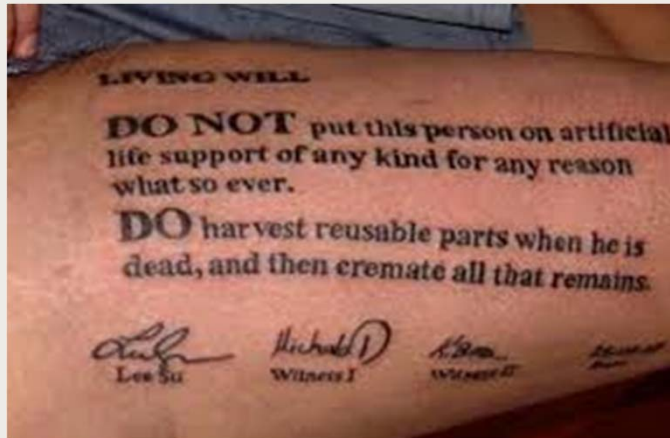


Decisions in the Form (continued)



1. Life-sustaining treatment: CPR and ventilator support?
2. Artificial hydration and nutrition (tube feeding)?
 - A. Give discretion to my agent.
 - B. Bar use of CPR and ventilator support when I am at end-of-life/have brain injury.
 - C. Provide aggressive treatment no matter what.

Use an HCPOA instead of a tattoo!



EMS DNR/ Physician Orders for Scope of Treatment (POST)



EMS DNR

EMERGENCY MEDICAL SERVICES (EMS) / DO NOT RESUSCITATE (DNR) FORM

Will your Patients' wishes to avoid unwanted resuscitation be honored during a medical emergency outside of the hospital?

The EMS Do Not Resuscitate (DNR) form developed by the EMS Bureau, Epidemiology and Response Division of the New Mexico Department of Health instructs EMS personnel to forgo resuscitative attempts in the event of a patient's cardiopulmonary arrest.

The form has 3 parts. One for your patient, one for your patient's medical records, and one for your patient to order an optional MedAlert Medication.

You may download FREE DNR Forms from emms.org

For individual EMS-DNR forms or questions about the implementation of the EMS-Do Not Resuscitate (DNR) program, contact the EMS Bureau at 505-476-8200.

ORDER FORM

To order your forms, send this order pre-paid orders by mail. The forms are available in packets of 10. **Send your check or money order (made out to the EMN Bureau) to:**
 EMS Bureau, 1301 Silver Road, Building F, Santa Fe, NM 87505

ATTENTION: DNR Program

Quantity per Set	Price	Total
1 (10 Forms)	\$5.00	\$
5 (50 Forms)	\$20.00	\$
10 (100 Forms)	\$30.00	\$

Ship to: Please type or Print
 Name: _____
 Address: _____
 City, State Zip _____
 Phone: _____

For more information
 Contact: DNR Program
 EMS Bureau
 1301 Silver Road, BLDG F
 Santa Fe, NM 87507
 PHONE: 505-476-8200
 FAX: 505-471-2121



South Carolina
 Physician Orders for Scope of Treatment (POST)

Patient Last Name: _____ Patient First Name (M): _____
 Patient Date of Birth: (MM/DD/YYYY) _____ Patient's Legal Representative Phone Number: _____
 Social Security Number (last 4 digits): (OPTIONAL) _____ Gender: M F Other
 Patient Mailing Address: (OPTIONAL) _____

Patient's Designation: _____

Section A
 Attempt Resuscitation/CPR (except CPR reserved for Treatment in Section B) If patient is an emancipated minor, when orders in B, C and D

Section B
 Do Not Attempt Resuscitation/DNR (except when in Section B) If patient is an emancipated minor, when orders in B, C and D

Section C
 Full Treatment. In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardiopulmonary as indicated. **Transfer to hospital and/or intensive care unit if indicated.**
 Treatment Plan: All treatments including breathing machine.

Section D
 Limited Treatment. In addition to care described in Comfort Measures Only, use medical treatment, intubation, or fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider tube invasive airway support (e.g. CPAP, BPAP). **Transfer to hospital if life-sustaining treatments. Transfer if comfort needs cannot be met in current location.**
 Treatment Plan: Provide medical treatments.
Section E
 Comfort Measures Only. Keep clean, warm and dry. Provide treatments to relieve pain and suffering through the use of any medication by any route, including, but not limited to, oral, intravenous, intranasal, rectal, and topical medications. Use oxygen and manual respiration of airway. Discontinue as needed for comfort. **Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.**
 Treatment Plan: Provide treatments for comfort through symptom management.

Section F
 ANTIHISTICS Use antihistics if the need is prolonged.
 Determine use or limitation of antihistics when infection occurs.
 No antihistics except for relief of pain and discomfort.
 Additional Orders: _____

Section G
 ARTIFICIALLY ADMINISTERED NUTRITION AND FLUIDS: (Oral food and fluids by mouth if feasible.)
 Long term artificial nutrition by tube. Trial period of 72 hours.
 Do not insert feeding tube. No IV fluids.
 Decide ahead of the situation arises. Decide ahead of the situation arises.
 Additional Orders: _____

Section H
 Signature of Physician, Advanced Practice Registered Nurse, or Physician Assistant
 My signature below indicates to the best of my knowledge that the patient has been diagnosed with a serious illness or injury that is expected to be permanent, life threatening, or fatal, and that these orders are consistent with the patient's medical history and current wishes.
 Physician/APRN/PA Signature: _____ Physician/APRN/PA Name: _____ Physician APRN PA (check one)
 State: _____ Physician/APRN/PA License #: _____ Physician/APRN/PA Phone Number: _____ Physician/APRN/PA License #: _____

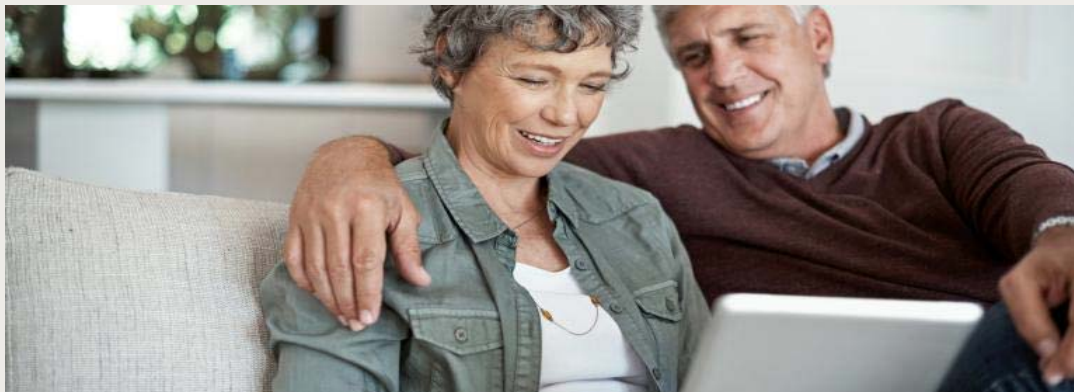
Section I
 Signature of Patient or Legal Representative
 I understand the risks, benefits, and consequences of the decisions made in this document. I understand that I am making these decisions on my own and that the document reflects those treatment preferences. If signed by a legal representative, the signature represents their belief that the patient would have authorized the above interventions.
 Signature: _____ Date: (MM/DD/YYYY) _____ Relationship (circle "self" if patient): _____
 Title: _____ Phone Number: _____

Section J
 Physician Assisting with POST Form Completion (if applicable)
 Print Name: _____ Date: (MM/DD/YYYY) _____ Phone Number: _____
 Position of Assistant: _____

FORM MUST ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

FORM 4071 (08/18)
 SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Have the Conversation with your family!



Where to keep your HCPOA:

REFRIGERATOR DOOR



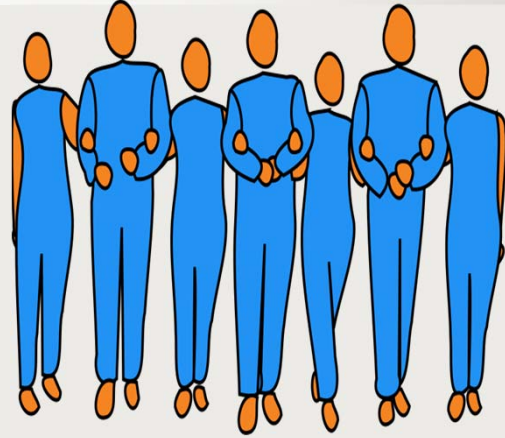
HEAD OF BED



Where your agent should keep your HCPOA:



Be sure your physician and hospital have a copy!



Help in filling out
SCHCPOA

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Chaplain

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