Conversations Change Lives
Advance Care Planning:
It All Begins With a Conversation
Our Objectives

• Introduce a difficult subject
• Discuss decisions that can be made or need to be made
• Review documents that should be completed
• Next steps
Having the Conversation

• Think about what matters most at end of your life based on goals of care, personal values and religious beliefs

• Timing is essential
  - Before events occur
  - Any changes in health care
  - Important events in other people’s lives that spur conversation
Why Are We Having This Conversation?

California Health Care Foundation Study -- 2012

- 60% said making sure family is not burdened by tough decisions is extremely important
- 56% have not communicated end of life wishes
- 80% said if seriously ill, they would want to talk to doctor about end of life care
- 93% report never having end of life conversation with doctor
Why Are We Having This Conversation?

California Health Care Foundation Study -- 2012

• 82% said it’s important to put their wishes in writing
• 23% have actually done it

• 70% said they would prefer to die at home
• 70% die in a hospital, nursing home or long term care facility
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Where do you fall between these issues ...

• Do you want to know basics or as much as you can?

• Do you want an idea of how long you have left or would you rather not know?

• Do you want a say in every decision related to your care or do you want doctors to “do what they think is best”? 
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When considering how long to receive medical care ... 

- Do you want to live as long as possible no matter what or is quality of life more important than quantity?
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How involved do you want family members or loved ones to be....

• Do you want them to follow your wishes even if they’re uncomfortable with wishes or do you want them to do what brings them peace, even if it’s against what you want?

• Do you want to be alone, surrounded by loved ones or something in between?

• Do you want everyone to know everything about your health or only the basics shared?
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Do you think your family and loved ones know exactly what you would want?

- Are you worried that you’ll receive too much or too little care near end of your life?

- What does being comfortable mean to you?
Health Care Decision Making

• Understand current and future medical illnesses

• Become educated about types of treatments that are acceptable in certain situations that are consistent with goals, values and religious or cultural beliefs

• Discuss medical decision making with health care team and family or trusted friends
Advance Care Planning

• Ongoing process to develop plans for future medical care if you are no longer able to speak for yourself

• Identify who you would want to speak for you

• Describe kinds of decisions you want them to make on your behalf based on your values, beliefs and goals of care
Making Sure Wishes, Values and Goals Are Known and Followed

• Advance Directive

• Health Care Power of Attorney

• POST document
Advance Directives

Living Will

- Legal document prepared usually in advance of illness that describes care that would or would not be acceptable to you if you are unable to speak for yourself
- Does not need to be prepared by lawyer or notarized
- Can be very specific or very vague
- Not always readily available
- Requires interpretation and physician order to be used
- May not apply to current medical condition
Health Care Power of Attorney

• Outlines who makes decisions for you if you are unable or unwilling to make decisions for yourself
• Does not require lawyer to complete; does not need to be notarized, but helpful
• Goes into effect if you are unable to make decisions, not if your family does not like the decisions you are making
Health Care Power of Attorney

If HCPOA has not been appointed, the following decision making order applies ...

• Legal guardian (if one has been appointed)
  • Spouse (unless judicially separated)
  • Majority of children
• Parents
• Majority of siblings
• Antecedents/descendants
POST Document

• Physician’s order that outlines wishes for medical treatment and goals of care when you have a known serious advanced illness; also translates living will into a physician’s order when you have life limiting and irreversible condition.

• More than an advance directive or health care power of attorney; recommended for patients with life limiting and irreversible conditions.

• Lists some of the medical treatments you can choose to have or not have. When completed, it must be honored by all health care professionals.
POST Document

• Can be completed by personal health care representative if you are no longer able to speak for yourself.

• To become valid, document must be discussed by you and/or your health care representatives and be appropriately completed. **It must be signed by a physician.**

• Of the three documents, the LaPOST document is most likely to ensure that you receive the care you want at end of life because it is a medical order and travels with you across health care settings.
## MISSISSIPPI PHYSICIAN ORDERS FOR SUSTAINING TREATMENT (POST)

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>Cardiopulmonary Resuscitation (CPR): Patient has no pulse AND is not breathing.</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Medical Interventions: If the patient has pulse AND breathing OR has pulse and is NOT breathing.</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Antibiotics: Use antibiotics if life can be sustained; Determine use or limitation of antibiotics when infection occurs; Use antibiotics only to relieve pain and discomfort.</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>Medically Administered Fluids and Nutrition: Administer oral fluids and nutrition if physically possible.</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>Patient Preferences as a Basis for This Post Form: This section to be filled out with patient direction.</td>
</tr>
</tbody>
</table>

### Section A: Cardiopulmonary Resuscitation (CPR)
- **Patient Last Name**: [Patient Last Name]
- **Patient First Name/Middle**: [Patient First Name/Middle]
- **Patient Date of Birth**: [Patient Date of Birth]
- **Effective Date (Format must be read at least annually)**: [Effective Date]

### Section B: Medical Interventions

#### Full Sustaining Treatment
- Transfer to a hospital if indicated. Includes intensive care. Treatment Plan: Full treatment including life support measures. Provide treatment including the use of intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardioversion as indicated, medical treatment, intravenous fluids, and comfort measures.

#### Limited Interventions
- Transfer to a hospital if indicated. Avoid intensive care. Treatment Plan: Provide basic medical treatments. In addition to care described in Comfort Measures below, provide the use of medical treatment; oral and intravenous medications; intravenous fluids; cardiac monitoring as indicated, noninvasive bi-level positive airway pressure; and bi-level positive airway pressure.

#### Additional Orders
- Vasopressors, dialysis, etc.

### Section C: Antibiotics

- Use antibiotics if life can be sustained.
- Determine use or limitation of antibiotics when infection occurs.
- Use antibiotics only to relieve pain and discomfort.

### Section D: Medically Administered Fluids and Nutrition

- Directing the administration of nutrition into blood vessels if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following:
  - Total parenteral nutrition, long-term if indicated.
  - Total parenteral nutrition for a defined trial period.
  - No parenteral nutrition.

- Directing the administration of nutrition by feeding tube if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following:
  - Long-term feeding tube if indicated.
  - Feeding tube for a defined trial period.
  - No feeding tube.

### Other Instructions

### Section E: Patient Preferences as a Basis for This Post Form

- **Patient has an advance healthcare directive** (per statute § 41-41-203): **YES**. Date of Execution: ______.
- I certify that the Physician Order for Sustaining Treatment is in accordance with the advance directive.

**Signature:** [Signature]
**Print Name:** [Print Name]
**Relationship:** [Relationship]

- **Patient is an unemancipated minor, direction was provided by the following** in accordance with §41-41-9, Mississippi Code of 1972:
  - Minor’s guardian or custodian.
  - Minor’s parent.
  - Minor’s grandparent.
  - Adult brother or sister of the minor.

- **Patient is an adult or an emancipated minor, direction was provided by the following** in accordance with §41-41-205, §41-41-211,

  - **Patient**
<table>
<thead>
<tr>
<th>Signature of Patient or Representative</th>
<th>Print Name</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of Primary Physician (POST must be reviewed and signed by a physician to be valid)</th>
<th>Print Name</th>
<th>Date (Required)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Health Care Professional Certifying (if other than Patient’s Primary Physician)</th>
<th>Print Name</th>
<th>Other Information</th>
<th>Date</th>
</tr>
</thead>
</table>

G. INFORMATION FOR PATIENT OR REPRESENTATIVE OF PATIENT NAMED ON THIS FORM

This form is used only for those who have been diagnosed with a terminal illness and have limited capacity, and must be completed by a patient or their representative. The signature of the patient or their representative is required. If the patient is not available, the signature of their authorized agent must be placed on the appropriate signature line.

H. DIRECTIONS FOR COMPLETING AND IMPLEMENTING FORM

I. REVIEW OF POST

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Resident and Location of Review</th>
<th>COPPS/Signature (Required)</th>
<th>Signature of Patient or Representative (Required)</th>
<th>Outcome of Review</th>
</tr>
</thead>
</table>

- No Change
- Form VEVLED: new form complete
- Form VEVLED: no new form

J. ART OF HOSPICE

We provide care only at the end of life.
Bringing Up The Subject

I need your help with something important …

• I’m okay now, but I’m worried that my situation may change, and I’d like to be prepared.
• I’d like your help as I plan for the future.
• I’d like to share my feelings with you about what I do and don’t want as my illness gets worse.
• Have you ever thought about what you’d like at the end of life? I’d like to hear your thoughts.
• I don’t want you to be confused about my wishes as I near the end of my life. Can we talk about what I want?
Other Things To Think About ...

• Who do I want to talk to about my end of life wishes?
• Who do I trust to speak for me if I become unable to speak for myself?
• When would be a good time to talk?
• Where would I feel most comfortable having this conversation?
• What are the most important issues to cover?
Other Things To Think About …

• What is most important in the last phases of my life?
• Do I want to be actively involved in decisions about my care?
• Are there situations or circumstances that I consider to be worse than death?
• Where do I want or not want to receive care at the end of life?
• What do I most want my loved ones to know about my wishes?
Making the Journey ...

• Packing list

• Sharing my wishes