Advance Care Planning

Getting Started
What we mean by “Advance Care Planning” and “Advance Directives”

If you were to become unable to make your own decisions or speak for yourself, how would your loved ones and healthcare team know what your preferences were?

Preferences might include what care you want, who you want involved in your care, and, importantly, what treatments/interventions you do NOT want.

Advance Care Planning is the ongoing process of thinking about and expressing your wishes about your healthcare choices. Advance Directives are written forms indicating your preferences.
Why is this important?

• Empower yourself and have your voice heard.
• Promote good collaboration with your healthcare team
• Gift to your Loved Ones

• What can happen without Advance Directives:
  • Caregiver distress
  • Family conflict
  • Your wishes not as able to be honored
  • Terry Schiavo – 1995
Why talking matters

Sharing your wishes for end-of-life care can bring you closer to the people you love. It’s critically important. And you can do it. Consider the facts:

92% of people say that talking with their loved ones about end-of-life care is important.

80% of people say that if seriously ill, they would want to talk to their doctor about wishes for medical treatment toward the end of their life.

32% have actually done so.

18% report having had this conversation with their doctor.

21% of people say they haven’t had the conversation because they don’t want to upset their loved ones.

Source: The Conversation Project National Survey (2018)

53% say they’d be relieved if a loved one started the conversation.

Source: Survey of Californians by the California HealthCare Foundation (2012) and Kaiser Family Foundation Serious Illness in Late Life Survey (2017)

97% of people say it’s important to put their wishes in writing.

95% say they are willing or want to talk about their end-of-life wishes.

37% have actually done it.

Source: Kaiser Family Foundation Serious Illness in Late Life Survey (2017)

-From The Conversation Project Starter Kit
Types of Advance Directives:

Who will make medical decisions for me if I can’t?

1. Medical Durable Power of Attorney
2. Proxy Decision Maker
   Colorado is not a ‘Next of Kin’ state for healthcare decisions
3. Guardian
MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

I. APPOINTMENT OF AGENT AND ALTERNATES

1. Declarant, hereby appoint:

Name of Agent

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 or express 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:

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

My signature below indicates that I understand the purpose and effect of this document:

Signature of Declarant Date

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More from life
Types of Advance Directives:

What Kind of Medical Care and Treatment do I want to have?

Living Will

Five Wishes
What Kind of Medical Care and Treatment do I want to have?

Do Not Resuscitate (DNR) Order

MOST (Medical Orders for Scope of Treatment)

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**Patient’s or Authorized Agent’s Directive to Withhold Cardiopulmonary Resuscitation (CPR)**

This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2

**Patient’s Information**

Patient’s Name ______________________ (Printed Name)  

# Applicable: Name of Agent/Legally Authorized Guardian/Parent of Minor Child  

Date of Birth: ______/_____/______ Gender: [ ] Male [ ] Female  

Eye Color: _______ Hair Color: _______  

Race/Ethnicity: [ ] Asian or Pacific Islander [ ] Black, non-Hispanic [ ] White, non-Hispanic  

[ ] American Indian or Alaska Native [ ] Hispanic [ ] Other  

# Applicable: Name of hospice program/provider: ______________________

**Physician’s Information**

Physician’s Name: ______________________ (Printed Name)  

Physician’s Address: ______________________  

Physician’s telephone: ______________________  

Physician’s Colorado License #: ______________________

**Directive Attestation**

Check **ONLY** the information that applies:

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More from life
Colorado Medical Orders for Scope of Treatment (MOST)

- **FIRST** follow these orders, then contact physician. Advanced Practice Nurse (APN), or Physician assistant (PA) for further orders if indicated.
- These Medical Orders are based on patient's medical condition & wishes. If section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- Everyone shall be treated with dignity and respect.

When in preparing these orders, please inquire whether patient has executed a living will or other advance directive. If completed, review for consistency with these orders and updating as needed. (see additional instructions on page 2.)

### A. CARDIOPULMONARY RESUSCITATION (CPR)

- **Person has no pulse and is not breathing.**
- Yes CPR: Attempt Resuscitation
- No CPR: Do Not Attempt Resuscitation

**NOTE:** Selecting “yes CPR” requires choosing “full treatment” in section B.

When not in cardiopulmonary arrest, follow orders in section B.

### B. MEDICAL INTERVENTIONS

- **Person has pulse and/or is breathing.**
- Full Treatment—primary goal to prolong life by all medically effective means:
  - In addition to treatment described in Section A, Comfort-Focused Treatment as follows:
  - Mechanical ventilation, medication, and invasive procedures.
  - Transfer to hospital as indicated.
  - Includes intensive care.
- Comfort-Focused Treatment—goal to treat medical conditions while avoiding burdensome measures:
  - In addition to treatment described in Section A, Comfort-Focused Treatment as follows:
    - Do not intubate.
    - No mechanical ventilation.
    - May use non-invasive positive airway pressure. Transfer to hospital if indicated.
    - Avoid intensive care.
- Comfort-focused Treatment—primary goal to maximize comfort:
  - Supportive care with medication by any route as needed, including non-invasive positive airway pressure, medication and palliative care.

**Additional Orders:**

### C. ARTIFICIALLY ADMINISTERED NUTRITION

- Always offer food & water by mouth if possible.
- Any surrogate legal decision maker (Medical Durable Power of Attorney (MPOA)), Proxy—Statute guardian, on other must follow directions in the patient’s living will, if any. Not completing this section does not imply any of the choices—further discussion is required. **NOTE:** Special rules for Proxy—Statute apply; see reverse side (“Completing the MOST form”) for details.
- Artificial nutrition by tube long term/permanent if indicated.
- Artificial nutrition by tube short term/temporary only. (May state term & goal in “Additional Orders”)
- No artificial nutrition by tube.

**Additional Orders:**

### D. DISCUSSION WITH (check all that apply):

- Patient
- Proxy—Statute
- Agent under Medical Durable Power of Attorney
- Other

**Signatures of Provider AND Patient, Agent, Guardian, or Proxy-by-Statute and Date (MANDATORY)**

Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects these treatment preferences, which may also be documented in a Medical Durable Power of Attorney. CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these Medical Orders for Scope of Treatment, they shall remain in full force and effect.

If signed by surrogate legal decision maker, preferences expressed must reflect patient’s wishes as best understood by surrogate.

**Patient/Physician Name / Signature**

**Witness**

**Relationship/Decision maker**

**Date Signed (MANDATORY)**

**Colorado License #:**

**HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY**

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More from life
Where do I get an Advance Directive Form?

The Conversation Project  http://theconversationprojectinboulder.org/


Colorado Care Planning Website (Content in English, Spanish, and Large Text)  https://coloradocareplanning.org/

Five Wishes  https://fivewishes.org/Home

COVID-19 TCP Presentation to learn advance care planning basics.  
https://www.youtube.com/watch?v=34_Rsb3HXeU&feature=youtu.be
Link to The Conversation Project's Being Prepared in the Time of COVID-19 Guide

COVID19 Treatment Decision Guide If you go to the hospital and become seriously ill, these are the questions you will likely be asked.  http://theconversationprojectinboulder.org/wp-content/uploads/2020/04/One-Page-COVID-19-Treatment-Decision-Support-Guide-.pdf
When and How do I start the conversation?

Here are some ways you could break the ice:

“I need your help with something.”

“Remember how someone in the family died—was it a ‘good’ death or a ‘hard’ death? How will yours be different?”

“I was thinking about what happened to __________, and it made me realize...”

“Even though I’m okay right now, I’m worried that __________, and I want to be prepared.”

“I need to think about the future. Will you help me?”

“I just answered some questions about how I want the end of my life to be. I want you to see my answers. And I’m wondering what your answers would be.”

-From The Conversation Project Starter Kit
What to talk about:

- When you think about the last phase of your life, what's most important to you? How would you like this phase to be?
- Do you have any particular concerns about your health? About the last phase of your life?
- What affairs do you need to get in order, or talk to your loved ones about? (Personal finances, property, relationships)
- Who do you want (or not want) to be involved in your care? Who would you like to make decisions on your behalf if you're not able to? (This person is your health care proxy.)
- Would you prefer to be actively involved in decisions about your care? Or would you rather have your health care team do what they think is best?
- Are there any disagreements or family tensions that you're concerned about?
- Are there important milestones you'd like to be there for, if possible? (The birth of your grandchild, your 80th birthday.)

- Where do you want (or not want) to receive care? (Home, nursing facility, hospital)
- Are there kinds of treatment you would want (or not want)? (Resuscitation if your heart stops, breathing machine, feeding tube)
- When would it be okay to shift from a focus on curative care to a focus on comfort care alone?

This list doesn't cover everything you may need to think about, but it's a good place to start. Talk to your health care team if you'd like them to suggest more questions to talk about.

REMEMBER:

- Be patient. Some people may need a little more time to think.
- You don't have to steer the conversation; just let it happen.
- Don't judge. A "good" death means different things to different people.
- Nothing is set in stone. You and your loved ones can always change your minds as circumstances change.
Planning does not mean giving up hope!

Knowledge is the Enemy of Fear
Questions?

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