VCU Palliative Care ECHO*

March 14, 2019
Basics of Advance Care Planning

*ECHO: Extension of Community Healthcare Outcomes
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The following Planning Committee and Presenting Faculty Members report having no relevant financial relationships:

Danielle Noreika, MD
Candace Blades, JD, RN

No commercial or in-kind support was provided for this activity
Helpful Reminders

• You are all on **mute** please **unmute** to talk

• If joining by telephone audio only, press *6 to mute and unmute
Helpful Reminders

Right click to your Zoom screen to rename your login; include your name and organization.
Helpful Reminders

Activate chat feature

Use the chat box to ask questions as they come to mind
What to Expect

I. Didactic Presentation
   20 minutes + Q&A

II. Case Discussions (x2)
   • Case Presentation
     5 min.
   • Clarifying questions from spokes, then hub
     2 min. each
   • Recommendations from spokes, then hub
     2 min. each
   • Summary (hub)
     5 min.

III. Closing and Questions

• Bi-weekly tele-ECHO sessions (1.5 hours)
• Didactic presentations developed by inter-professional experts in palliative care
• Website: www.vcuhealth.org/pcecho
• Email: pcecho@vcuhealth.org

Let’s get started!
# Hub Introductions

## VCU Team

| Clinical Director   | Danielle Noreika, MD, FACP, FAAHPM  
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<th>Medical Director/Fellowship Director VCU Palliative Care</th>
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<td>Clinical Experts</td>
<td>Egidio Del Fabbro, MD – VCU Palliative Care Chair</td>
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<td>Jason Callahan, MDiv – Palliative Care Specialty Certified</td>
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<td></td>
<td>Tamara Orr, PhD, LCP – Clinical Psychologist</td>
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<td>Diane Kane, LCSW – Palliative Care Specialty Certified</td>
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<td>Felicia Hope Barner – RN</td>
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<td>Candace Blades, JD, RN – Advance Care Planning Coordinator</td>
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<td>Brian Cassel, PhD – Palliative Care Outcomes Researcher</td>
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<tr>
<td>Support Staff</td>
<td>Teri Dulong-Rae / Bhakti Dave, MPH</td>
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<td>Program Manager</td>
<td>David Collins, MHA</td>
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<td>Practice Administrator</td>
<td>Frank Green</td>
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<td>IT Support</td>
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Spoke Participant Introductions

Name and Institution
Basics of Advance Care Planning

Candace Blades, JD, RN
March 14, 2019
Objectives

The participant will be able to:

1) Understand the Advance Care Planning (ACP) process
2) Identify the different types of ACP documents and the legal requirements for each type.
3) Become familiar with communication skills to facilitate ACP conversations.
What is Advance Care Planning? (ACP)

ACP is a process of planning for future medical decisions. To be effective this process includes....

• **Reflection** on goals, values, and beliefs (including cultural, religious, spiritual, and personal)

• **Understanding** possible future situations and decisions

• **Discussion** of these reflections and decisions with those who might need to carry out the plan.

ACP is about thoughtful *conversation* that yields a quality ACP document such as an Advance Directive.
Advance Care Planning begins with basic advance care planning/advance directives for healthy adults and continues through the approach to end of life.

**ACP Over Time**

Advance Directive  Advance Care Planning

**PHASE 1**
Healthy or with reversible illness

**PHASE 2**
Early onset, chronic conditions

**PHASE 3**
Progressive, frequent complications

**PHASE 4**
Hospice eligible

Chronic and Curative Care

AD

DNR

Palliative Care

Hospice

D-DNR / POLST / MOLST

**Disease Progression**

POLST: Physician orders for life sustaining treatment
(In Virginia: POST—Physician Orders for Scope of Treatment)

Source: AHA CPI Analysis, 2012, with contributions from 2012 CTAC data And 2011 Center to Advance Palliative Care data.
• Enhanced goal-concordant care
• Improved quality of life reduced suffering
• Higher patient satisfaction
• More and earlier hospice care
• Fewer hospitalizations
• Time to make informed decisions and fulfill personal goals

• Better patient and family coping
• Eased burden of decision making for families
• Improved bereavement outcomes
• Less non-beneficial care and costs
Advance Directives

ACP involves communication of important healthcare wishes to family, loved ones and healthcare providers. **Advance Directives** are legal documents that express those wishes.

- Living Will/Advance Directive
- Healthcare Power of Attorney (Health Care Agent)
- DNR and DDNR
- POST
Advance directives can be:

• Created by any adult ≥18 years of age or emancipated minors.
• Created by an individual with sufficient mental capacity. Decisional capacity includes the ability to understand the relevant information, the choices and the ability to state a decision. Capacity is task specific. Individuals with mild dementia may understand the issues related to ACP even if they no longer have the ability to live independently, for example. Capacity is presumed but where there are concerns about lack of capacity, a provider should make a determination.
• Cancelled, revoked, or modified at any time, but only by the individual who created the advance directive. A Healthcare Agent and/or family cannot create, revoke or override a patient’s AD.
Virginia Standard Advance Directive

The standard Virginia Advance Directive:

• Allows for the appointment of a Healthcare Agent

• May contain Living Will instructions about treatment in the event of imminent death or where there is no awareness of self or surroundings or no ability to interact with others and treatment is very unlikely to improve the situation

• Allows for a statement about Anatomical gifts
VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, _______________________, willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II AND III BELOW.)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

A. Appointment of My Agent

I hereby appoint _______________________, ______________________, as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

B. Powers of My Agent

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make health care decisions in the following way:
Who decides if no agent is appointed?

1. Legally appointed guardian
2. Patient’s spouse (except where divorce action has been filed)
3. Adult children
4. Parent of patient
5. Adult siblings
6. Any blood relative in descending order of relationship
Do Not Resuscitate
DNR/DDNR

- **Inpatient**: A provider must enter a DNR order.

- **Outpatient**: Inpatient DNR orders do **not** follow a patient upon discharge. If the patient or Agent wishes to continue the patient's DNR status upon discharge, a provider must complete a paper Durable DNR (DDNR) form.
Must be signed by a provider and the patient if “1” is checked above or patient’s representative if “2” is checked above. Please review the informed consent policy for obtaining proper telephone consent and procedure for a patient who cannot physically sign.
POST
Physician Orders for Scope of Treatment

• POST is a medical order set for patients with life-limiting illness or patients who are frail and elderly

• POST has a DNR section plus orders for other medical interventions to apply or withhold in pre-arrest situations depending on the wishes of the patient.

• POST is portable like the DDNR

• POST does not replace an Advance Directive. It builds upon and complements the patient’s Advance Directive.
POST should be considered for...

- Any patient whose death within the next year would not come as a surprise.
Sample ACP Documents
ACCP

Document 1

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, ____________, voluntarily make known my wishes in the event that I am incapacitated to make an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II, AND III BELOW)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

A. Appointment of My Agent

I hereby appoint ____________ as my agent to make health care decisions on my behalf as authorized in this document.

If the primary physician named above is not reasonably available or if the primary physician does not act as my agent, then I appoint as successor agent to serve in that capacity:

Name of Successor Agent

B. Powers of My Agent

The powers of my agent shall include the following:

1. To consent to or refuse to consent to any type of health care, including, but not limited to, artificial nutrition, artificial hydration, and cardiopulmonary resuscitation (CPR).

2. To request, receive, and review any oral or written information regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directives as stated in this advance directive

3. To employ and discharge my health care providers.

4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.

5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law.

6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.

7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law, if the study offers the prospect of direct therapeutic benefit to me.

8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law, if the study aims to increase scientific understanding of any condition that I may have or otherwise to promote human welfare, even though it offers no prospect of direct benefit to me.
9. To make decisions regarding resuscitation during any time that I am admitted to any health care facility, consistent with the following directions.

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

IN SP ADE TIME Period

SECTION II: MY HEALTH CARE INSTRUCTIONS

YOU MAY USE ANY OF THE BOXES IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT HAVE AN Agent. IF YOU CHOOSE NOT TO PROVIDE WRITTEN DIRECTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES IF EXISTENT, AND OTHERWISE ON YOUR BEST INTERESTS. IF YOU ARE ABLE, CIRCLE THE BOXES YOU WISH TO DIRECT YOUR HOSPITAL CARE. IF YOU ARE INCAPABLE, THIS DOCUMENT WILL BE APPLIED AS IF YOU SHOULDED THE MEDICAL STATUTORY OF YOUR ORGS, RISKS AND TREATMENT FOR EXISTING.

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover.

[CHECK ONLY 1 BOX IN THIS PART 1]

☐ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/ventilator (breathing machine), kidney dialysis or antibiotics. I understand that I will receive treatment to relieve pain and make me comfortable. (OK)

☒ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OK)

☐ I want my care to be provided by your attending physician. Specific instructions about care are given, including specific instructions about treatments that you do want medically appropriate or don’t want. It is important that your instructions here do not conflict with other instructions you have given (such as advance directives).

☐ IN SP ADE TIME Period

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover consciousness or ability even with medical treatment.

[CHECK ONLY 1 BOX IN THIS PART 2]

☐ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/ventilator (breathing machine), kidney dialysis or antibiotics. I understand that I will receive treatment to relieve pain and make me comfortable. (OK)

☐ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OK)

☒ I want to my treatments for a period of time in the hope of some improvement of my condition. I suggest 90 days as the period of time after which such treatment should be stopped if my condition has not improved. The entire time period is at the discretion of my agent or agent in consultation with my physician. I understand that I will receive treatment to relieve pain and make me comfortable. (OK)

☐ YOU MAY WRITE YOUR INSTRUCTIONS ABOUT YOUR CARE THAT ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO 

RECOVER CONSCIOUSNESS, OR ABILITY EVEN WITH MEDICAL TREATMENT. IF YOU DO WANT MEDICALLY APPROPRIATE, OR DO WANT IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN (SUCH AS ADVANCE DIRECTIVES).
3. I provide the following specific instructions concerning my health care:

[Insert specific instructions here]

SECTION III: ANATOMICAL GIFTS

[Insert specific instructions here]

[Insert specific instructions here]

AFFIRMATION AND RIGHT TO REVOKE

By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

[Signature]

The declarant signed the foregoing advance directive in my presence. [Two adult witnesses needed]

[Names of witnesses]
ACP Document 2
9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

SECTION II: MY HEALTH CARE INSTRUCTIONS

[You may use any or all of Parts I & II in this section to express your health care wishes even if you do not have an agent. If you do not choose to complete Parts I & II, the instructions on the back of this form will apply.]

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

   (CHECK ONLY 1 BOX IN THIS PART 1)
   
   [ ] I do not want any treatment to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/positive pressure breathing machines, kidney dialysis or antibiotics. I understand that I will still receive treatment to relieve pain and make me comfortable. (OR)
   
   [ ] I want all reasonable measures to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

   [ ] [You may write here your own instructions about your care when you are dying, including specific instructions about treatments that you do want or do not want.] It is important that your instructions clearly state your wishes. If your instructions are not clear, they may not be followed.]

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment:

   [CHECK ONLY 1 BOX IN THIS PART 2]
   
   [ ] I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/positive pressure breathing machines, kidney dialysis or antibiotics. I understand that I will still receive treatment to relieve pain and make me comfortable. (OR)
   
   [ ] I want all reasonable measures to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

   [ ] I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest ________ as the period of time after which each treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with any physician. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

   [ ] You may write here your instructions about your care when you are unable to interact with others and are not expected to recover this awareness. This will override any previous instructions about treatments that you do want or do not want. It is important that your instructions state your wishes clearly.]

   [ ] If I am terminal, have uncontrolled pain or cannot communicate, I want only palliative care in the hope of a change in condition I want to be treated.
3. I provide the following other instructions concerning my health care:

You may refusebasic medical treatment and any specific forms of treatment that I so request, whether or not medically appropriate. OR MAY REQUIRE TREATMENT THAT IS MEDICALLY APPROPRIATE. OR MAY REQUIRE TREATMENT THAT IS MEDICALLY APPROPRIATE, OR MAY REQUIRE TREATMENT THAT IS MEDICALLY APPROPRIATE, OR MAY REQUIRE TREATMENT THAT IS MEDICALLY APPROPRIATE, OR MAY REQUIRE TREATMENT THAT IS MEDICALLY APPROPRIATE.

SECTION III: ANATOMICAL GIFTS

YOU MAY USE THIS DOCUMENT TO RECORD YOUR DECISION TO DONATE YOUR ORGAN, EYES AND TISSUE OR YOUR WHOLE BODY AFTER YOUR DEATH. IF YOU DO NOT MAKE THIS DECISION HERE OR IN ANY OTHER DOCUMENT, YOUR AGENT CAN MAKE THIS DECISION FOR YOU. IF YOU SPECIFICALLY INSTRUCTED TO DO SO, YOUR DECISION WILL TAKE PRECEDENCE OVER ANY INSTRUCTIONS THAT YOU HAVE GIVEN IN THIS DOCUMENT.

I donate my organs, eyes, and tissues for use in transplantation, therapy, research and education. I direct that all necessary measures be taken to accord to the highest medical suitability of my organs, eyes or tissues for donation. I understand that I may revoke any directions at the Department of Charitable Gifts or the donor registry, www.DonateLifeVirginia.org, and that I may use the donor registry to amend or revoke my donations OR.

I donate my whole body for research and education.

[Write here any specific instructions you wish to give about anatomical gifts.]

I am Hepatitis C positive, but wish to donate.

[Signature]

AFIRMATION AND RIGHT TO REVOKE:

By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

[Date: 7-26-2016]

[Signature]

The declarant signed the foregoing advance directive in my presence: [No witnesses needed].

We then signed the form.

This form satisfies the requirements of Virginia’s Health Care Decisions Act. If you have any questions about this document or would like to develop a different form that meets your specific needs, you should talk with your attorney. It is your responsibility to provide a copy of your advance directive to your treating physician. You also should sign copies to your spouse, adult children and/or friends. For more information on filing this advance directive in the state of Virginia, visit the Virginia Advance Health Care Directives Registry at http://www.VirginiaAdvCare.org. This form is provided by the Virginia Hospital and Healthcare Association as a service to its members and the public. (June 2013, www.vhhha.com A-15).
DURABLE POWER OF ATTORNEY
OF

I. PRINCIPAL AND ATTORNEY-IN-FACT

I, [Name], who resides at [Address], hereby revoke any general power of attorney that I have heretofore given to any person and do hereby appoint [Name], residing at [Address], to serve as my attorney-in-fact, to act for me in any lawful way with respect to the subjects indicated below.

If [Name] resigns or is unable or unwilling to serve as my attorney-in-fact, I appoint [Name], to serve as my successor attorney-in-fact.

II. EFFECTIVE TIME

This Power of Attorney shall become effective immediately and shall continue to be effective until my death or until revoked. In the event of my disability or incompetency, from whatever cause, this power of attorney shall not thereby be revoked.

III. POWERS OF ATTORNEY-IN-FACT

My attorney-in-fact shall have the power to act in my name, place and stead in any way which I myself could do with respect to the following matters to the extent permitted by law:

A. BANKING TRANSACTIONS:

Conduct any business with banks and other financial institutions, including but not limited to the following:
- Signing and endorsing all checks and drafts in my name.
- Withdrawing funds from accounts.
- Opening, maintaining and closing accounts or other banking arrangements.
- Making inquiries regarding existing accounts.
- Hiring safe deposit boxes, entering into and removing articles from them.
- Borrowing money, pledging property as security, and negotiating terms of debt payments.
- Applying for and receiving letters of credit, credit cards and travel's checks, and
  giving an indemnity or other agreement in connection with letters of
B. STOCK AND BOND TRANSACTIONS:
- Buy, sell, pledge and exchange stocks, mutual funds, bonds, options, commodity futures and all other types of securities in my name.
- Sign, accept and deliver in my name certificates, contracts or other documents relating to the foregoing, including agreements with brokers or agents.
- Exercise voting and other rights and enter into agreements relating thereto.

C. REAL ESTATE TRANSACTIONS:
- Manage, sell, transfer, lease, mortgage, pledge, refinance, insure, maintain, improve, and perform any and all other acts with respect to real property and interests in real property that I may own now or later acquire.
- Defend, settle and enforce by litigation a claim to real property and interests in real property that I own now or later acquire.
- Buy, lease or otherwise acquire real property or an interest in real property.
- Execute deeds, mortgages, releases, satisfactions and other instruments relating to real property and interests in real property that I own or later acquire.

D. PERSONAL PROPERTY TRANSACTIONS:
- Buy or otherwise acquire ownership or possession of, sell or otherwise dispose of, mortgage, pledge, assign, lease, insure, maintain, improve, pay taxes on, and otherwise manage tangible personal property and interests thereof that I now own or later acquire.

E. PERSONAL AND FAMILY CARE:
- To do all acts necessary to maintain the customary standard of living of my spouse and myself, including but not limited to, providing and paying for medical care, shelter, clothing, food, transportation, airfare and dues for organizations to which I hold membership.
- To authorize my admission to a medical, nursing, residential, or similar facility and to enter into agreements for my care, and to authorize medical and surgical procedures for me.
- Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any similar state laws, I authorize any health care provider to disclose to the person named herein as my “attorney-in-fact,” any pertinent individually identifiable health information. My attorney-in-fact shall constitute my “Personal Representative” as defined by HIPAA.
F. GOVERNMENT ASSISTANCE:
   • Claim and collect benefits from social security, Medicare, Medicaid, or other government programs or civil or military.

G. INSURANCE AND ANNUITY TRANSACTIONS:
   • Obtain, modify, renew, convert, rescind, pay the premium on or terminate insurance and annuities of all types for myself and for my family and other dependents.
   • Designate the beneficiary of the contract, but the attorney-in-fact may be named beneficiary under a contract, or an extension, renewal, or substitute for it, only to the extent the attorney-in-fact was named as a beneficiary under a contract procured by the principal before signing this Power of Attorney.
   • Surrender and receive the cash value, borrow against or pledge any insurance or annuity policy.

H. ESTATE AND TRUST TRANSACTIONS:
   • To act for me in all matters that affect a trust, probate estate, guardianship, conservatorship, escrow, custodianship or other fund from which I am now, claim to be or later become entitled, as beneficiary, to a share or payment.

I. LEGAL ACTIONS:
   • To act for me in all legal matters, whether claims in my favor or against me, including but not limited to retaining attorneys on my behalf; appearing for me in all actions and proceedings, commencing actions in my name, signing all documents, submitting claims to arbitration or mediation, settling claims and paying judgments and settlements.

J. TAXES:
   • Prepare, exercise any available election, and sign tax returns and related documents.
   • Pay taxes due, collect refunds, post bonds, receive confidential information.
   • Represent me in all income tax matters before any federal, state or local tax collecting agency.

K. RETIREMENT PLANS:
   • To act for me in all matters that affect my retirement or pension plans, including but not limited to selecting payment options, designating beneficiaries, making contributions, exercising investment powers, making "rollovers" of plan benefits, borrowing or selling.
IV. GENERAL PROVISIONS

1. Reclamation By Third Parties. I hereby agree that any third party receiving a duly executed copy or copy of this document, may rely on and act under it. Revocation or termination of this Power of Attorney shall be ineffective as to the third party unless and until actual notice or knowledge of that revocation or termination has been received by the third party. I, for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any third party from any and all claims because of reliance on this instrument in good faith.

2. Severability. If any provision hereof is found to be invalid or unenforceable, such invalidity or unenforceability shall not affect the other provisions of this document, and such other provisions shall be given effect without the invalid or unenforceable provision.

3. Revocation. I may revoke the Power of Attorney at any time.

4. Accounting. My attorney-in-fact shall provide an accounting for all funds handled and all acts performed as my attorney-in-fact, but only upon my request or the request of a personal representative or fiduciary acting on my behalf. Any requirement of my attorney-in-fact to file inventories and accounts with the county clerk or with the court is specifically waived.

5. Compensation and Reimbursement. My attorney-in-fact shall not be compensated for services provided on my behalf pursuant to this Power of Attorney. My attorney-in-fact shall be reimbursed for all reasonable expenses incurred relating to his or her responsibilities.

6. Personal-Benefit Permitted. So long as my attorney-in-fact is acting in good faith and in my best interest, my attorney-in-fact is permitted to personally benefit or profit from transactions taken on my behalf.

7. Commingling of Funds. My attorney-in-fact is not permitted to commingle my funds and assets with his or her own.

8. Liability of Attorney-in-Fact. All persons or entities who in good faith endeavor to carry out the provisions of this Power of Attorney shall not be liable to me, my estate, or my heirs, for any damages or claims arising because of their actions or inactions based on this Power of Attorney. My estate shall indemnify and hold them harmless. A successor attorney-in-fact shall not be liable for acts of a prior attorney-in-fact.
IN WITNESS WHEREOF, the undersigned has executed Power of Attorney on the date set forth below:

Date: 6/14/2010

Signature of [redacted]

ACKNOWLEDGMENT OF NOTARY PUBLIC

Commonwealth of Virginia

County of [redacted]

On this 11th day of June 2010, before me, the undersigned Notary Public, personally appeared [redacted], personally known to me (or proved to me on the basis of satisfactory evidence) to be the individual who signed the foregoing Power of Attorney and acknowledged to me that he or she executed the same in his or her authorized capacity, and that by such signature, the person executed the instrument.

Witness my hand and seal:

Signature of Notary Public:

This document was prepared by:

[Need another witness]

[Redacted]
Durable Do Not Resuscitate Order
Virginia Department of Health

Physician’s Order
I, the undersigned, state that I have a sound physician/patient relationship with the patient named above. I have certified to the patient’s medical record that neither a person authorized to consent on the patient’s behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which states that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a “Person Authorized to Consent on the Patient’s Behalf” with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of Person Authorized to Consent on the Patient’s Behalf is required)

☐ C. The patient has not executed a written advanced directive stating that life-prolonging procedures be withheld or withdrawn. (Signature of Person Authorized to Consent on the Patient’s Behalf is required)

I hereby direct any and all qualified health care providers, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (heart massage, endotracheal intubation and other advanced life support measures, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient’s cardiac or respiratory arrest. I further direct such providers to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

[Signature]
Physician’s Name

[Signature]
Physician’s Signature

[Signature]
Emergency Phone Number

[Signature]
Patient’s Signature

[Signature] of Person Authorized to Consent on the Patient’s Behalf

Copy 1 – To be kept by patient
Durable Do Not Resuscitate Order

Patient’s Full Legal Name [REDACTED]

Physician’s Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient’s medical record that before a person authorized to consent on the patient’s behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (check 1 or 2):

☐ 1. The patient is capable of making an informed decision about withholding or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is incapable of making an informed decision about withholding or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternative actions or inaction.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a “Person Authorized to Consent on the Patient’s Behalf” with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of “Person Authorized to Consent on the Patient’s Behalf” is required)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of “Person Authorized to Consent on the Patient’s Behalf” is required)

I hereby direct my/our attending health care provider(s), on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient’s cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

[Redacted]

Emergency Phone Number

[Redacted]

[Redacted]

[Redacted]
Durable Do Not Resuscitate Order

Virginia Department of Health

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified that the patient's medical records show that he/she or a person authorized to act on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (ex. check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent, or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf" is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf" is required.)

I hereby direct any and all qualified health care personnel, commencing on the effective date stated above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other invasive airway management, artificial ventilation, resuscitation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest.

[Redacted]

Emergency Phone Number

[Redacted]

Patient's Signature

[Redacted]

Copy 2 – To be kept in the patient’s permanent medical record.
How do I begin a conversation about ACP?

Explain:

• All individuals ≥18 should plan ahead for an unexpected injury or illness that leaves them unable to make healthcare decisions for themselves. Planning includes:
  
  • Doing this well in advance of the emergency.
  
  • Selecting a healthcare decision maker, an Agent, that is well suited for the role.
  
  • Having enough conversation with their Agent so that the decisions their Agent makes for them are in alignment with the decisions they would make for themselves if they were able.
  
  • Include the Agent and other family and loved ones if possible.
Selecting the Healthcare Agent: Important considerations

• Have I asked this person if he/she is willing?
• Have I talked with this person enough so that he/she understands my preferences, values, and goals?
• Will this person follow my preferences, even if they differ from their own?
• Can this person ask questions and make decisions in difficult or emotional situations? Can they keep a “cool head” in a crisis? Can they stand up for me with the healthcare team and family members and other loved ones who might disagree?
Try Asking These Questions

For all patients:

• “What experiences have you had with people that have been seriously ill? Have you, or anyone close to you ever had to make decisions for a loved one who could no longer speak for him or herself? What did that experience teach you about what you would want and not want if you were ever in the same situation?”

• “What level of physical and mental function do you need in order to have a good quality of life? What gives your life meaning?”

For patients with serious chronic and progressive or life limiting illness:

• “What fears or concerns do you have about your illness going forward?”

• “What are your goals for care and treatment as you move forward?” (Explore the difference between quantity and quality of life.)

**Clarify the meaning of words and phrases!**
Resources


• Critical Conversations: ACP Tools for Physicians, NPs and PAs https://honoringchoices-va.org/courses/critical-conversations/
Case Presentation

Alison Ryan

VCUHealth
Case 1: Question

What is the nature of your question?
Treatment options (goals of care); Advance Care Planning

Main question:
In the case of a young patient with metastatic disease at diagnosis, discuss options for when goals of care, advance care planning should be initiated.
At what point do we opt not to pursue further anticancer therapy?
Case 1: History

Brief history of illness and other comorbid disorders

43 yo diagnosed with Stage IV triple negative breast cancer July 2018, s/p 4 c ddAC, s/p weekly taxol, Carbo with progression 1/19. Phase 2 Clinical trial therapy, 1 cycle Pemetrexed/Sorafenib with rapid progression of hepatic metastasis.

Admitted for 2nd time in 2 weeks with abdominal pain, progressive N/V. significant progressive hepatic dysfunction due to disease burden. Patient then received fixed dose capecitabine for 3 days prior to discharge home, expiring at home two days later.
Case 1

**Patient social and spiritual history**
Patient lived at home with teenage child, older daughter out of the house. Currently disabled. Very involved mother providing care and support.

**Patient Symptom Assessment**
- Pain
- Agitation
- Nausea
- Constipation
- Delirium

Advance Directive completed 3/1
Durable DNR order completed 3/1
Accessing CME credit
After our live ECHO session, visit www.vcuhealth.org/pcecho

Click “Claim CME and Provide Evaluation”
Submit your evaluation to claim your CME
View previously recorded ECHOs for CME

To view previously recorded sessions and claim credit, visit
www.vcuhealth.org/pcecho

Click “Curriculum”
View previously recorded ECHOs for CME

Select the session you would like to view
View previously recorded ECHOs for CME

Click “Tests” to view video of the session and take a short quiz for continuing education credit.
THANK YOU!

We hope to see you at our next ECHO