Advance Care Planning in the Oncology Setting

Amy Bailey, LMSW
Tracy Bargeron, MSN, RN
Summer Bates, FNP-BC, ACHPN

Navigating Advance Care Planning (ACP):

Chart Review, Introduction, Discussions, Documentation

Conflict of Interest: All speakers for today's presentation have declared no conflict of interest.

Amy Bailey, LMSW *Clinical & Macro*
MyMichigan Health
Advance Care Planning Specialist
Ethics Coordinator
Amy.Bailey@mymichigan.org

Summer Bates, FNP-BC, ACHPN
Covenant HealthCare
Lead Palliative Care NP
ACP Facilitator
Summer.Bates@Chs-Mi.Com

Tracy Bargeron, MSN, RN
Covenant HealthCare
Advance Care Planning and
Community Outreach Specialist
ACP Instructor
TBargeron@chs-mi.com

Objectives

- Identify differences in Advance Care Planning (ACP) processes specific to Michigan Law.
- Describe ACP documents that are legally recognized in Michigan.
- Identify approaches to promoting ACP conversations with patients with oncological diagnoses throughout their oncology journey.
- Understand how ACP conversations may spark Goals of Care (GoC) conversations.
- Gain a better understanding of the MI-POST law and the MI-POST form.

Advance Care Planning (ACP) Services

- ACP is a ***process*** of communication focused on planning for future health care decisions and how one's wishes would be communicated.
  - Most likely results in a written document appointing a Medical Decision Maker – Patient Advocate, as well as addressing future treatment preferences such as resuscitation.
  - ACP is an **ongoing process** that should be revisited periodically throughout a person's life span and should be shared by multidisciplinary team members.

"There is evidence that advance care planning positively impacts the quality of end-of-life care."

Brinkman-Stoppelenburg, Reitjens & van der Heide, 2014

"Effective ACP is an essential component of person-centered end-of-life and palliative care."

Waldrop & Meeker, 2012

What is an Advance Health Care Directive?

There are two main types:

- **Durable Power of Attorney for Health Care (DPOA-HC)**
  - Includes designation of a patient advocate AND *may include* a person's wishes
  - Alternative **"DOCUMENT"** titles:
    - Advance Medical Directive
    - Advance Directive
    - Patient Advocate Designation
    - Medical Power of Attorney

- **Living Will**
  - Contains statement of treatment decisions
  - DOES NOT usually designate a patient advocate

Legal requirements driven by state law.

Living Wills are not *legally* recognized in Michigan.

What if…?

What if you had a medical emergency today that left you unable to make decisions about your care?

Who would speak for you?

Would they know your treatment preferences?

98

Polling Question # 1

Have you completed a legal document designating a medical decision maker for yourself (commonly known as an Advance Directive, Patient Advocate Designation, or Durable Power of Attorney for Health Care)?

- Yes
- No
- Working on it
- Have never thought about it

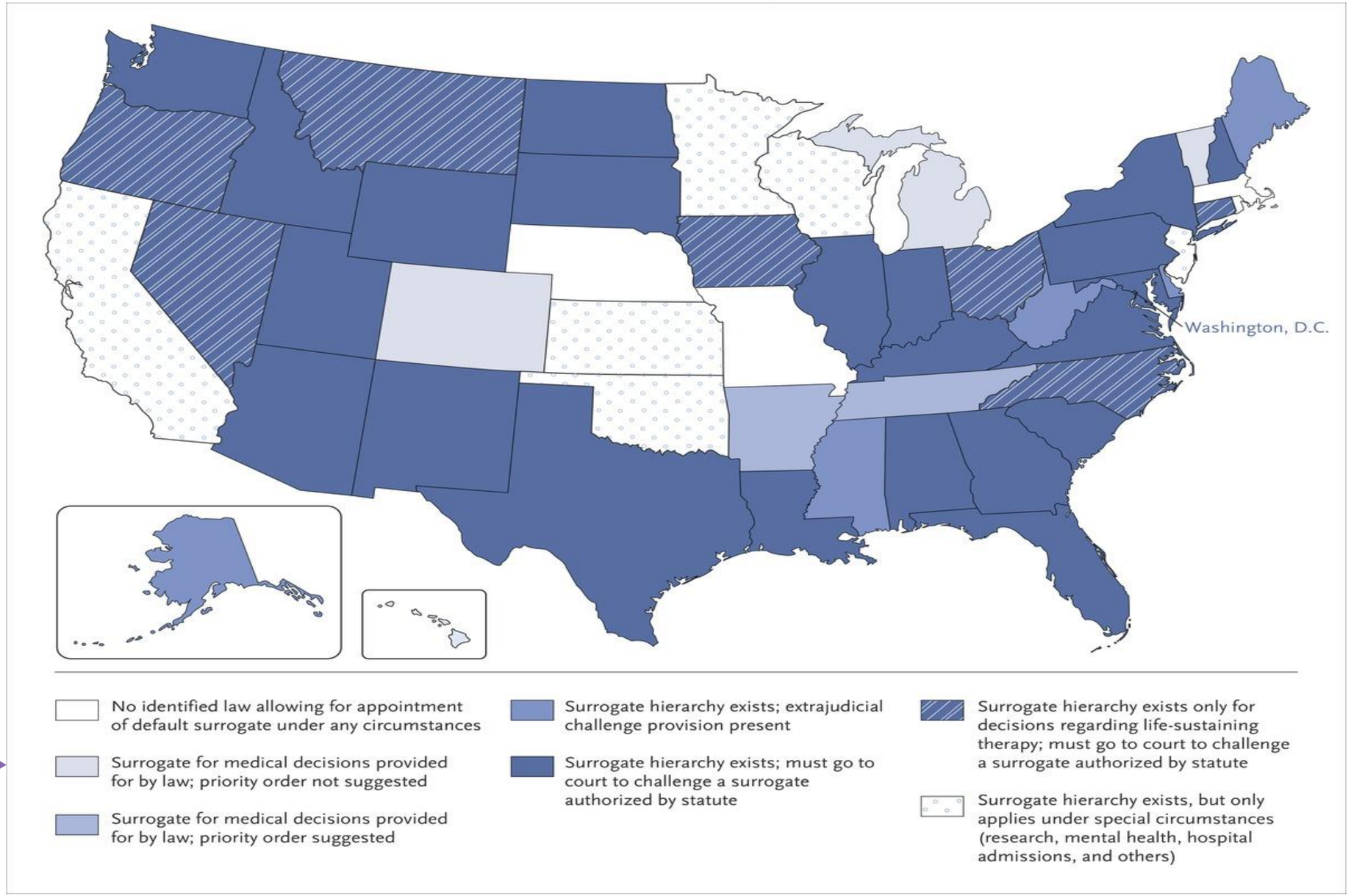
Michigan’s Laws are Unique

Our state does not have a Next of Kin law for making medical decisions for another adult.

Living Wills are not recognized in our state—we must obtain consent for care.

Competent adults (those who do not have a court-appointed Legal Guardian) and Adults with Capacity can create a Patient Advocate Designation to identify their preferred surrogate decision maker (Patient Advocate).

State Laws Regarding Surrogate Decision Makers



Michigan →

Polling Question # 2

Does your employer have an Advance Care Planning policy?

- Yes
- No
- Not Sure

Michigan Advance Care Planning Documents

Advance Care Planning Documents

Document	Common Titles	Purpose of Document
Advance Health Care Directive	•Advance Directive •Durable Power of Attorney for Health Care •Medical Power of Attorney •Patient Advocate Designation •Living Will: recognized in other states as an Advance Health Care Directive - not legally recognized in Michigan	•Designation of a medical decision-maker (Patient Advocate). •Often, it includes medical treatment preferences.
Out-of-Hospital Do Not Resuscitate (OOH-DNR) Order	•Out of Hospital DO-NOT-RESUSCITATE (DNR) ORDER •Emergency Medical Prehospital Care DO-NOT-RESUSCITATE ORDERS	Portable Medical Order for DNR status to be followed prehospitalization by health care personnel and Emergency Medical Service (EMS) personnel.
Michigan Physician Orders for Scope of Treatment (MI-POST)	This is a standardized form that includes two double-sided pages: •MDHHA-5836, Michigan Physician Orders for Scope of Treatment (MI-POST) •MDHHS-5837, Michigan Physician Orders for Scope of Treatment (MI-POST) Patient and Family Information Sheet	Portable Medical Orders to be followed by EMS personnel only - *may or may not include DNR wishes.*

Comparison of ACP Documents

	Patient Advocate Designation/Durable Power of Attorney for Health Care/ Advance Directive	Out-of-Hospital DNR Order	MI-POST
Type of document	**Legal document.**	**Portable medical order** that applies to care outside of hospital admission.	**Portable medical order** that applies to care outside of hospital admission or ED visit.
Who can a document be created for?	Adults with Capacity.	• Any Adult, **regardless of health.** • Parent on behalf of a minor with advanced illness.	Adults with **advanced illness or frailty** (12 months or less life expectancy).
Who completes the document?	Adults with Capacity.	• Adults with capacity or a patient advocate or guardian of an adult who lacks capacity. • Parent on behalf of a minor.	Adults with capacity or a patient advocate or guardian of an adult who lacks capacity.
What is communicated in the document?	Designates a patient advocate and any successor patient advocate(s); may include preferences for medical and/or mental health care to **guide the patient advocate.**	**Do Not Resuscitate (DNR) order for outside of the hospital.** It can be used as guidance in acute care.	• **DNR or Full Code wishes** • Specified Medical orders for: Comfort, Selective, or Full Treatment • Additional orders (TF, dialysis, etc.) It can be used as guidance in acute care.
Does it expire?	No.	No.	**Yes, after 12 months (may be reaffirmed).**
Must it be on special paper/color?	No, but certain wording must be included. Copies: electronic, paper, and photo are acceptable.	No. Copies: electronic, paper, and photo are acceptable – individual county Medical Control Authority may have specific requirements.	Yes, documents are provided by the state and must have a pink border. Copies: electronic, paper, and photo are acceptable.
Required Signatures	• Adult for whom the document is for • 2 adult witnesses - cannot be patient advocate, family members, healthcare, or mental health facility employees where patient receives care, or employee of a life or health insurance provider, heir, or presumptive heir. • Patient Advocate(s)	• Adult for whom the document is for (or patient advocate or guardian) • **2 adult witnesses** - one may be a family member. If signed by the patient's guardian, neither can be a family member. • **Physician signature**	• Adult for whom the document is for (or patient advocate or guardian) • **Physician, NP or PA completing the document.** • Individual preparing form (if indicated) • **Does not require witnesses**
Actionable by EMS	No.	Yes.	Yes.

ACP Document Examples

FIVE WISHES®

MY WISH FOR:

The Person I Want to Make Care Decisions for

The Kind of Medical Treatment I Want or

How Comfortable I Want to B

How I Want People to Treat M

What I Want My Loved Ones to K

print your name

birthdate

MAKING CHOICES MICHIGAN
Discuss. Decide. Document.

Advance Directive

Durable Power of Attorney for Healthcare
(Patient Advocate Designation)

Introduction

This document provides a way for an individual to create a Durable Power of Attorney for Healthcare (Patient Advocate Designation) and other documentation that will meet the basic requirements for this state.

This **Advance Directive** allows you to appoint a person (and alternates) to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **Patient Advocate**. This document gives your Patient Advocate authority to make your decisions *only when you have been determined unable to make your own decisions by two physicians, or a physician and a licensed psychologist*.

It *does not* give your Patient Advocate any authority to make your financial or other business decisions.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values, and this document with your Patient Advocate.** If you do not closely involve your Patient Advocate, and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

This document was developed to meet the legal requirements of Michigan. It is not designed to replace the counsel of your attorney.

This is an Advance Directive for *(print legibly)*:

Name: _____ Date of Birth: _____ Last 4 digits of SSN: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

Address: _____

City/State/Zip: _____

Where I would like to receive hospital care (whenever possible): _____

Designation of Patient Advocate Form

HONORING
Healthcare Choices

Designation of Patient Advocate Form and Directions for Healthcare

(Durable Power of Attorney for Healthcare)

For:

Name: _____

Date of Birth: _____

This is an important legal document. If you have any questions, you may want to discuss them with your doctor, attorney, or a certified advance care planning facilitator.

Portions used with permission from MyMichigan Health and Honoring Healthcare Choices Michigan.

olor/Duplex/Staple

Advance Directive

Durable Power of Attorney for Health Care
Patient Advocate Designation

INTRODUCTION

This document includes the required content to be legally recognized, in the state of Michigan, as a Durable Power of Attorney for Health Care, also known as an Advance Directive which includes the appointment of a Patient Advocate.

This **Advance Directive** allows you to appoint a person (and alternates) to make your medical and mental health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **Patient Advocate**. Your Patient Advocate only has the authority to make your decisions *when you have been determined unable to make your own decisions by two physicians, or a physician and a licensed psychologist.*

This form is referred to as the *"Durable Power of Attorney for Health Care"* (DPOA-HC) and should not be confused with a *"Durable Power of Attorney"* (DPOA) which relates to decisions about your financial matters. Your Patient Advocate named in this DPOA-HC does not have the authority to make your financial or other business decisions.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values and this document with your Patient Advocate.**

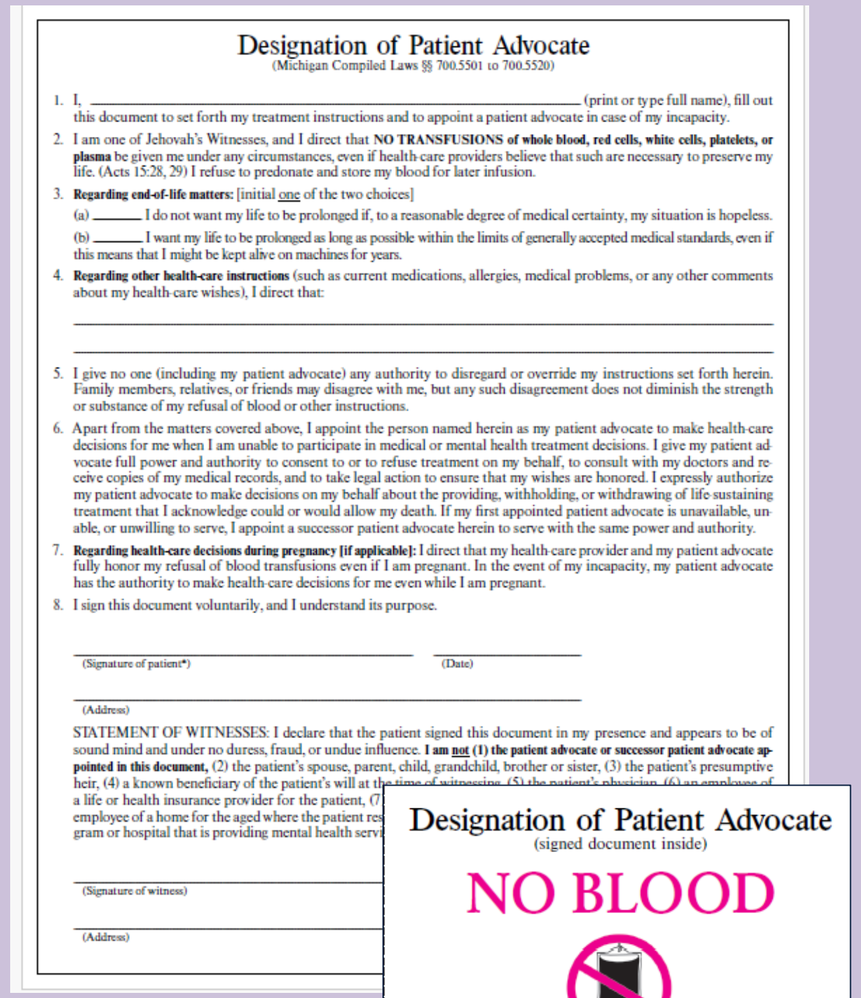
Please note: This document is considered a guide. Your wishes must be shared with your provider at time of treatment. Your providers may decline to follow your written instructions, or your Patient Advocate's instructions, if (1) they are not medically indicated or medically achievable, (2) any requested treatment is not available, (3) complying would be inconsistent with the law or court-ordered treatment, (4) there is an emergency endangering your life.

For more information or assistance in completing this Advance Directive, contact a member of the Advance Care Planning Team:
989.583.6292 **Tel** · CovenantACP@chs-mi.com **Email**

DPOA-HC documents for specific groups

MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Common form completed by patients who are Jehovah's Witnesses.



Designation of Patient Advocate
(Michigan Compiled Laws §§ 700.5501 to 700.5520)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a patient advocate in case of my incapacity.
2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.
3. **Regarding end-of-life matters:** [initial one of the two choices]
   (a) _____ I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.
   (b) _____ I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.
4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:
5. I give no one (including my patient advocate) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.
6. Apart from the matters covered above, I appoint the person named herein as my patient advocate to make health-care decisions for me when I am unable to participate in medical or mental health treatment decisions. I give my patient advocate full power and authority to consent to or to refuse treatment on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. I expressly authorize my patient advocate to make decisions on my behalf about the providing, withholding, or withdrawing of life-sustaining treatment that I acknowledge could or would allow my death. If my first appointed patient advocate is unavailable, unable, or unwilling to serve, I appoint a successor patient advocate herein to serve with the same power and authority.
7. **Regarding health-care decisions during pregnancy [if applicable]:** I direct that my health-care provider and my patient advocate fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my patient advocate has the authority to make health-care decisions for me even while I am pregnant.
8. I sign this document voluntarily, and I understand its purpose.

(Signature of patient*) (Date)

(Address)

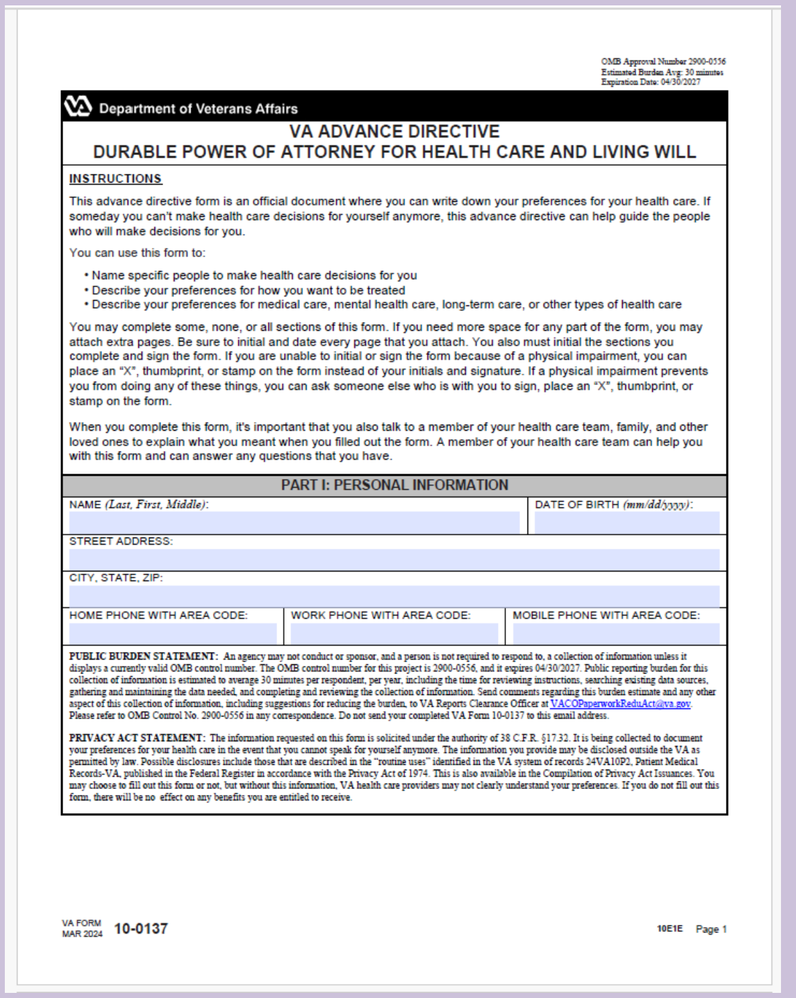
STATEMENT OF WITNESSES: I declare that the patient signed this document in my presence and appears to be of sound mind and under no duress, fraud, or undue influence. **I am not (1) the patient advocate or successor patient advocate appointed in this document,** (2) the patient's spouse, parent, child, grandchild, brother or sister, (3) the patient's presumptive heir, (4) a known beneficiary of the patient's will at the time of witnessing, (5) the patient's physician, (6) an employee of a life or health insurance provider for the patient, (7) employee of a home for the aged where the patient res... gram or hospital that is providing mental health servi...

(Signature of witness)

(Address)

Designation of Patient Advocate
(signed document inside)

NO BLOOD



OMB Approval Number 2900-0556
Estimated Burden Avg: 30 minutes
Expiration Date: 04/30/2027

Department of Veterans Affairs

VA ADVANCE DIRECTIVE
DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL

INSTRUCTIONS

This advance directive form is an official document where you can write down your preferences for your health care. If someday you can't make health care decisions for yourself anymore, this advance directive can help guide the people who will make decisions for you.

You can use this form to:

- Name specific people to make health care decisions for you
- Describe your preferences for how you want to be treated
- Describe your preferences for medical care, mental health care, long-term care, or other types of health care

You may complete some, none, or all sections of this form. If you need more space for any part of the form, you may attach extra pages. Be sure to initial and date every page that you attach. You also must initial the sections you complete and sign the form. If you are unable to initial or sign the form because of a physical impairment, you can place an "X", thumbprint, or stamp on the form instead of your initials and signature. If a physical impairment prevents you from doing any of these things, you can ask someone else who is with you to sign, place an "X", thumbprint, or stamp on the form.

When you complete this form, it's important that you also talk to a member of your health care team, family, and other loved ones to explain what you meant when you filled out the form. A member of your health care team can help you with this form and can answer any questions that you have.

PART I: PERSONAL INFORMATION

NAME *(Last, First, Middle)*:	DATE OF BIRTH *(mm/dd/yyyy)*:
STREET ADDRESS:	
CITY, STATE, ZIP:	
HOME PHONE WITH AREA CODE:	WORK PHONE WITH AREA CODE: / MOBILE PHONE WITH AREA CODE:

PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0556, and it expires 04/30/2027. Public reporting burden for this collection of information is estimated to average 30 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0556 in any correspondence. Do not send your completed VA Form 10-0137 to this email address.

PRIVACY ACT STATEMENT: The information requested on this form is solicited under the authority of 38 C.F.R. §17.32. It is being collected to document your preferences for your health care in the event that you cannot speak for yourself anymore. The information you provide may be disclosed outside the VA as permitted by law. Possible disclosures include those that are described in the "routine uses" identified in the VA system of records 24VA10P2, Patient Medical Records-VA, published in the Federal Register in accordance with the Privacy Act of 1974. This is also available in the Compilation of Privacy Act Issuances. You may choose to fill out this form or not, but without this information, VA health care providers may not clearly understand your preferences. If you do not fill out this form, there will be no effect on any benefits you are entitled to receive.

VA FORM MAR 2024 **10-0137** 10E1E Page 1

Common form completed by patients with a Veteran's affiliation.

Differences within the VA:

- **Social Workers are allowed to sign as a witness**
- **Patient Advocate Signature page is not present.**

How does your practice address these documents?

Polling Question 3

Does your practice have specific Advance Care Planning documents?

- Yes
- No
- Not Sure

Documents That Do Not Give Authority To Make Medical Decisions

MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Document	Common Titles	Purpose of Document
Personal Representative - HIPAA	•Authorization to Disclose Protected Health Information •Nomination of Agent as Healthcare Personal Representative •Authorization for Patient Representative	Designation of individuals who may receive protected health information. (no decision-making rights)
Power of Attorney (POA)	•Power of Attorney •Durable Power of Attorney •General Power of Attorney	Designation of a financial decision-maker Person named as the decision maker is usually referred to as an “Attorney-in-Fact” or “Agent”. On rare occasions may include the designation of a Patient Advocate.
Care Facility -Specific Treatment Wishes	Usually includes the name of the facility – Common misuse of "Advance Directives" may appear in the title.	Treatment wishes to be honored within a skilled nursing facility (SNF) – may be used as a reference in other settings. Person for whom the document is for is usually referred to as a “Resident”.

These documents usually include statements that **do not** delegate authority to make treatment decisions, such as entering into care contracts or being appointed as a representative regarding HIPAA. These are often found in **financial POA or HIPAA-only** documents.

Review of Document

Basic Validation:

- Appointment of a Patient Advocate giving the authority to make medical treatment decisions.
- Signatures:
  - Patient - dated
  - Two Witnesses – if present, date must match the patient's date

➢ *Electronic signatures are not allowed in Michigan – briefly allowed during COVID.*

Limitations on Witnesses

Witnesses cannot be:

- Less than 18 years of age
- **Primary or Successor Patient Advocate**
- Patient's spouse, parent, child, grandchild, or **presumptive heir**
- A known beneficiary at the time of witnessing
- An employee of a health or life insurance provider for the patient
- **An employee of a health care facility that is treating the patient**
- A healthcare provider currently involved in the treatment of the patient

Please note: Michigan *does not* require a notary or an attorney's signature.

➢ ***Two*** *witness signatures are required. If signed by a notary, this signature serves as one of the two required signatures.*

Patient Advocate Signatures

700.5507 Patient advocate designation; statement; acceptance.
Sec. 5507.

Validating/Vetting

A Patient Advocate must sign acceptance of the patient advocate designation before acting as a Patient Advocate.

The acceptance of a designation as a patient advocate must include *substantially* all of the following statements:

1. This patient advocate designation is not effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift as described in section 5506, the authority remains exercisable after the patient's death.

2. A patient advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised on the patient's own behalf.

3. This patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

4. A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

5. A patient advocate shall not receive compensation for the performance of the patient advocate's authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of the patient advocate's authority, rights, and responsibilities.

6. A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.

7. A patient may revoke the patient's patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

8. A patient may waive the patient's right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if the waiver is made, the patient's ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates the patient's intent to revoke.

9. A patient advocate may revoke the patient advocate's acceptance of the patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

10. A patient admitted to a health facility or agency has the rights enumerated in section 20201 of the public health code, 1978 PA 368, MCL 333.20201.

Statements of Authority

Validating/Vetting

- Patient advocate(s) authority is not active at the time of document signing. The authority to make medical decisions on the patient's behalf does not become active until the patient has been determined by either two physicians or a physician and a licensed psychologist to lack capacity for medical decision-making.

➢ *Financial or combined financial and medical power of attorney documents often lack that wording.*

Polling Question #4

Who in your workplace is responsible for validating Advance Care Planning documents? *(select all that apply)*

- ○Nurse
- ○Social Worker
- ○Medical Assistant
- ○Provider (Physician, Nurse Practitioner, or Physician Assistant)
- ○Other
- ○No one
- ○Not sure

Approaches to Promoting ACP Conversations

Meeting with Patients

…

Early ACP Discussion

"It always seems too early, until it is too late."

Many individuals find conversations about serious illness, the possibility of losing the capacity to make decisions, and end-of-life care difficult.

Starting the conversation early often helps ease the stress.

Be prepared for the conversation.

Communication Skills

Good communication is the key!

- **Exploring the meaning of words/phrases**
  "What does 'being a burden' mean to you?"
- **Paraphrase/clarify**
  "You mentioned you do not want to suffer like your mom. Could you share more about what that means?"
- **Ask, "Anything else?"**
  Ask until the patient has nothing further to share.
- **Listen for and summarize themes**
  "You mentioned it is hard to share your wishes with your children. The conversation can help with that conversation."
- **Affirm/reaffirm purpose of conversation**
  "You mentioned you are not sure what you may or may not want. I hope to help you today think about some situations that may help with this."

- **Verbalize empathy**
  "Thank you for sharing what must have been a difficult time for you."
- **Use the Ask-Teach-Ask technique**

1. First, ASK…what the individual understands.
2. Then, TEACH…provide information to improve understanding.
3. Last, ASK (i.e., Teach-Back)…assess understanding of information before moving on.

"These are new ideas for many people, so I want to make sure I was clear. Can you tell me what you now understand about ___?"

- **Remain value-neutral**
  Avoid words, phrases, or nonverbal expressions that may communicate personal biases or values.
- **Pay attention to nonverbal communication**

Polling Question #5

Which role in your practice assists patients with completing new Advance Care Planning documents?
(select all that apply)

- ○Nurse
- ○Social Worker
- ○Medical Assistant
- ○Provider (Physician, Nurse Practitioner, or Physician Assistant)
- ○Other
- ○No one
- ○Not sure

Preparing for ACP Conversation

Chart review:

- Patient ability to complete ACP documents
- Pre-existing ACP Document
- Past code status
- Medical history/Recent Hospitalizations

Plan who should be included

- Patient Advocates joining in-person or via phone conference

Is the patient able to complete a document?

Review the chart for any documentation of a lack of decision-making capacity or competency that may limit the patient's ability to complete a document.

Capacity versus Competency - Both terms address decision-making ability, in comparison:

- **Competency** - A *legal* term, declared only by a judge.
  - If a person is ruled to be **incompetent**, a guardian is assigned.
  - If the patient has a court-appointed guardian, the patient cannot complete a document.
  - A court-appointed guardian cannot complete a patient advocate designation on the patient's behalf.
  - A court-appointed guardian cannot delegate their authority without notifying the court.

- **Capacity** - *Clinical* term, determined by a physician or a licensed psychologist.
  - Capacity is not all or nothing, as a patient's cognitive status may wax and wane. Understanding may be present for simple decision-making (such as a patient advocate designation), but not for complex medical decisions, such as treatment options.

➢ *According to Michigan law, documentation that a patient lacks the capacity to make medical decisions must be completed by two physicians or one physician and a licensed psychologist before another person makes decisions for them.*

Capacity Determination

A basic clinical capacity determination involves assessment of the ability to:

- **Communicate verbally, in writing, or otherwise**
- **Demonstrate understanding of the current medical situation**
- **Demonstrate an understanding of the benefits and risks of treatment**
- **Make a decision that is consistent over time**

➢ ***For complex situations, consider consulting a psychiatrist for a more detailed evaluation.***

Who makes decisions if a patient lacks capacity?

Court-appointed guardian or designated patient advocate.

- Must have a legal document of appointment or designation on file.

➢ *Michigan law: Documentation that a patient lacks the capacity to make medical decisions must be completed by two physicians or one physician and a licensed psychologist before another person makes decisions for them.*

If a guardian is not appointed or a patient advocate is not legally designated.

- Follow your agency's Decision Maker Policy, which may include:
  - Documentation of preferred decision-maker
  - Next of kin hierarchy

➢ *Remember, lack of capacity does not mean a patient loses autonomy.*

Before Meeting with the Patient:
Review for Existing ACP Documents

- Review EMR for existing documents
  - Advance Medical Directive, OOH-DNR order, MI-POST
  - Who is responsible for this task?

- Shared by Referral Source
  - Is the document accessible in your system?
  - EPIC CareLink or Care Everywhere?

Reviewing for the presence of a document **builds patient trust**, as patients are often frustrated when they are asked if they have a document and have already previously provided one.

➢ *Print off a copy to have ready for your meeting with the patient.*

Polling Question #6

Does your EMR system allow for easy identification of the presence of Advance Care Planning documents?

- Yes
- No
- Not Sure

Medical History/Recent Hospitalizations

- **Emergency Contacts**
- **Past conversations with other health care team members**
  - CPR
  - Prognosis
  - Treatment preferences
  - Preferred Medical Decision Maker
- **Past intubation or CPR**
- **Look for the presence of illness that may warrant more discussion**
  - COPD – ventilator
  - Renal failure – dialysis
  - Dementia – feeding tube
  - Cancer Treatment (curative or palliative) – additional support

Meeting with Patients Who Have a Valid Document on File

- **Review printed copy with patient:**
  - Assess the patient's understanding of the document.
  - Confirm patient advocate designation.
  - Confirm preferences for care.
    - Any changes with diagnosis or a change in condition.*
  - Reaffirmation signature and scan updated copy into EMR.
  - Explore previous conversations with patient advocates.
  - Who else has a copy of the document?
- **Are all patient advocate(s) listed as contacts in the EMR?**
- **Does your EMR show who has been named as a patient advocate, and is the hierarchy of patient advocates easily identified?**

➢ *If the document is older, often the patient has forgotten that they created the document.*

***If the patient would like to make changes, advise that they may need to create a new document.**

What if the patient has multiple documents?

- **Identify which document was most recently signed by the patient.**
  - **The most recently created document revokes any previously created document.**

- **Common misconception:**

"A document signed by an attorney overrides a document created by a health care system."

  - **All versions meeting Michigan legal requirements are created equal.** **(MCL700.5506-5520)**
  - **A document signed by a notary or an attorney does not guarantee that the document is valid.**

➢ *A health system's version of a document signed in 2020 revokes a document signed by an attorney in 2018.*

What if the patient has a document and…

- **Spouse was named as primary, and now they are divorced or legally separated.**
- **Wants to remove one of three prior patient advocate designations.**
- **Spouse was named as primary and has early dementia or is otherwise incapacitated.**

Revocation

- **Patients may revoke a previous patient advocate designation at any time and in any manner by which he/she is able to communicate an intent to revoke.**
- **In Michigan, patients who have been determined to lack capacity may still revoke a previous patient advocate designation.**

➢ ***Recommendation is to complete a new patient advocate designation.***

Revocation of Patient Advocate Designation

When someone wishes to remove a previously designated patient advocate(s), it is recommended that a new Advance Directive (Durable Power of Attorney for Health Care) be created, which will cancel out the old document. If this is not feasible at the time, this form may be used to communicate wishes to revoke a previously designated patient advocate. This document should be scanned into the medical record as a cover page to the Advance Directive to be changed. This document is not necessary if a new Advance Directive can be completed.

Regarding the Advance Directive created by

_____ on _____.
(Patient Name) (Date signed by Patient)

I, _____ hereby revoke my previous
(Patient Name)

designation of _____ as my Patient Advocate.
(Patient Advocate Name)

_____ _____
Signature of Patient Date

Meeting with Patients Who Have a Document on File that is *NOT* Valid

- **Review printed copy with patient and educate on why the document is not valid.**

Reason why

- Assess the patient’s understanding of the document.
- Document is for financial POA, not health care, or is a HIPAA Personal Representative.
- Witness signature dates do not match the patient’s signature date
- Witness Limitations
- Missing witness signatures or only signed by notary
- Out-of-state document, not meeting Michigan requirements
- Missing pages
- Wallet card
- Changes made to the document

Meeting with Patients Who Do Not Have a Document on File

"We are asking all our adult patients if they have created a legal document naming your trusted medical decision-maker. Common titles of this document are Durable Power of Attorney for Health Care, Patient Advocate Designation, or Advance Directive. Have you created this type of document?"

Helpful Hint

If a patient :

- has VA services
- is a retired UAW worker
- has Created a Trust

they often have a document.

Patient Shared They *Have* a Document at Home

- ***How will this be obtained?***
  - Bring to next appointment
  - Upload into the patient portal
  - Email
  - Fax
  - Request their attorney to forward
  - Mail
- **Assess the patient's understanding of the document.**
- **Validation**
- **Explore what is included in the document:**
  - Patient advocate designation
  - What authority
  - Treatment preferences
  - Who has a copy

Once on file, this will meet ***MOQC Goal 103: Designated Advocate Documented on a Legally Recognized Document in the Inpatient or Outpatient Medical Record.***

Patient Shared They ***Have Not*** Completed a Document

- *Begin the conversation by normalizing the topic and exploring their understanding of the purpose, providing education as needed.*

"Now that you are receiving care with us, we recommend that you create a legal document designating the person(s) you would want us to contact for medical decision-making if you could not communicate for yourself.
Whom would you trust to be your decision-maker?"

  - ***If a person shares who they want as their preferred decision-maker, make sure this is clearly documented in the chart!***

- Assess the patient's understanding of Advance Care Planning.

Role Play:
Understanding of Advance Care Planning

Education on the Importance of Creating a Document

After exploring what they understand, education may be needed to address any misunderstandings.

Share the importance of designating a Patient Advocate:

- Michigan does not have a Family Consent Law.
- Assuring the health care team is speaking to the person they trust.
- Giving authority to make **medical** decisions in most settings.
  - Policies often differ between care settings (inpatient/outpatient).

Option to include treatment preferences:

- Promotes alignment of care with the individual's goals and values.
- Many people believe an Advance Directive is only needed if they wish to limit care. So, it is important to provide education that the AD may include care they do want.

➢ *Be prepared to share resources.*

Common Response from Patients

- **“My daughter will make decisions for me.”**
  - *“Having a legal document in place that designates your daughter can help make sure this is the person the health care team reaches out to if ever needed?”*

- **“My spouse will make decisions.”**
  - Response: *“What conversations have you had about your care preferences with your spouse?”* Share a situation where the spouse may not be able to act as a patient advocate.

- **“My family knows my wishes.”**
  - *Response: “That’s great that you have shared your wishes. There are many circumstances when a legal document is required to allow your family to make certain decisions.”*

What authority can be delegated to the Patient Advocate?

- **Access Medical Records**
- **Employ or discharge anyone on the health care team.**
- **Consent to, refuse, withdraw, or withhold care.**
  - **Must clearly and convincingly state the authority to withhold life-sustaining treatment *(if desired).***

Usually included.

- **Anatomical Gift (Organ Donor Registry overrides stated wishes on organ donation).**
- **Authority to make Mental Health decisions must be specifically stated – specific content r/t mental health is desired.**

➢ ***Patients often desire funeral wishes.***

The patient advocate's authority ends upon the patient's death, unless the patient is participating in the Gift of Life program. A Funeral Representative form could be recommended.

Selecting a Patient Advocate

- **Qualities to look for in a Patient Advocate**
  - Must be age 18 or older
  - Willingness to accept the role
  - Ability to make decisions in a crisis
  - Willingness to discuss medical condition & preferences for care
  - Will this person honor your wishes even if they disagree with your decisions
  - Easy to contact and will maintain contact – does not have to be present, must answer the phone!

  - **A patient advocate does not have to be a family member.**
  - **Education that the patient advocate designation may be revoked or changed at any time by the patient.**

Reassure the patient that their patient advocates' authority does not become effective until it is determined they cannot make their own decisions.

Patient Advocate Selection: Additional Tips

- **Recommend at least one successor.**
  - ***Designation of "co-appointment" of patient advocates is strongly discouraged.***
- **Offer handouts describing the role of a patient advocate.**
- **Ask how they will explain the role to their patient advocate(s).**
- **If a patient advocate is present, include them in the conversation.**
  - **Share that your additional conversation will assist with preparing for this role.**
- **If the patient advocate cannot be present, how will they be informed:**
  - **Follow-up conversation**
  - **Call at the end of the meeting to summarize**

Approaches to Document Completion

Non-Clinical Team Member

- Understanding the legal purpose of the document.
- Identifying Patient Advocate(s)
- Review the authority delegated to the patient advocate.
- Discuss treatment preferences they wish to include in their document.
- Share education tools on CPR, Feeding Tube, and Mechanical Ventilation, or other resources as indicated.
- If all sections are completed, obtain signatures.
- Plans to share the document and wishes with patient advocates and other health care team members.
- Create a list of possible topics to discuss with the clinical team.
- Education on when to review and reaffirm.

Clinical Team Member

In addition to the Non-Clinical Steps

- Explore understanding of illness
- Explore previous experiences w/ serious illness for themselves or someone close to them.
- Identify any beliefs or values that may influence medical decisions.
- Provide a scenario on quality of life & treatment options.
- Explore understanding of CPR, provide education.

➢May transition into a more detailed Goals of Care conversation, aligning medical treatments with what matters most to the patient.*

**Discussed in more detail in the next slides.*

Transitioning to Document Completion

ACP conversation continues to discuss:

- Understanding of health status
- Past experiences with serious illness
- Learning what matters most to the individual
- Goals in the event of a serious brain injury
- Understanding of CPR

Once completed, summarize the conversation and transition to document completion – ask if they are ready to complete the document.

5 Minute Break

ACP conversations may occur at the same time as or lead to Goals of Care (GoC) conversations

ACP and GoC Conversations: Likes and Differences

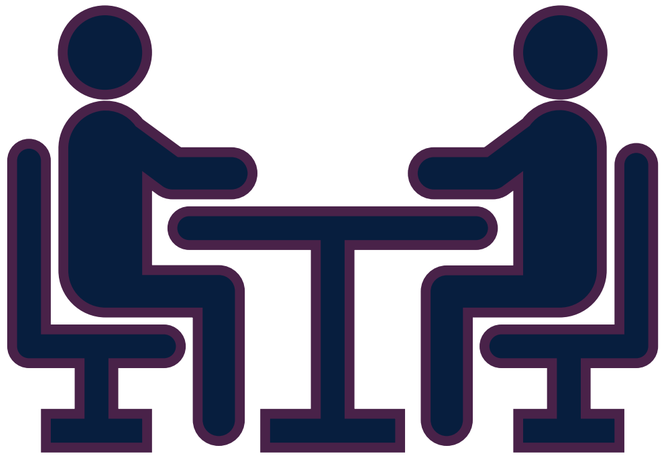
ACP and GoC conversations both involve exploring a person's values, beliefs, and what matters most to them to better align the care they want with the care that is provided.

ACP and GoC conversations differ, as ACP conversations focus on preparing for *future* healthcare decisions, whereas GoC conversations focus on *current* healthcare decisions.

As a person's disease progresses, ACP conversations will often become more GoC-oriented.

When an ACP conversation is taking place with a person who already has a serious illness, future healthcare decisions may also impact the present; thus, the conversation becomes both ACP and GoC-oriented. If the person facilitating the conversation is not a provider, GoC decisions would be shared with the provider for any further discussion.

REMAP: A framework for Goals of Care Conversations



REMAP

- **R**eframe
- **E**xpect Emotion
- **M**ap what is important

Exploration

- **A**lign
- **P**lan to match values

Goals of Care

Why do I need a guide?

- Helps you stay on track during the conversation, as these conversations trigger many emotions and stories.
- Once you address emotions, this helps as a guide to refocus.
- If you follow the same guide each time with your patients, you are less likely to forget any of the important aspects.
- These methods are well researched and guided to meet the needs of patients with serious illness.
- Developed in a way to help you build rapport and trust, which is crucial when assisting someone with difficult decisions, as we often do.

Reframe

REMAP

Begins with asking permission and assessing understanding.

Ask the patient to share their understanding of illness.

"What have your doctors shared with you about your disease process?"

""Has your treatment team shared with you the intent of your treatment?"

"Tell me what you understand about your medical condition(s)?"

"Tell me how things have been for you over the last year to 6 months."

"What problems do you think you may have in the future?"

"Would it be ok if we talked about what lies ahead with your illness?"

Explore experiences with past illness with someone close to them.

Reframe

REMAP

Listen for gaps in understanding and offer time to share information. *"Anything else?"*

IF they have a good understanding

"It sounds like you have a good understanding of your illness. Thank you for sharing."

Ask any family present if there is more to share.

"Given where you are in your illness, this seems like a good time to talk about where we go from here."

IF they do not have a good understanding.

Non-providers:

- Write down questions to take to their provider.
- Offer general information.

Providers:

"It seems that we are in a different place now than we were 6 months ago."

Reframing when there is no good understanding.

First, ask permission to share information on the topic they did not provide a good understanding of.

- **Ask them how they would like that information.** *Fine details or general big picture?*
- **Focus on one topic affecting them the most as not to overwhelm them.**
- **Explain in a way that they will understand.** *Relate to past experiences.*
- **Once you explain, ask them to repeat what you explained to them.**

  "Sometimes I am not the best at explaining things to people. Can you tell me what you heard me say?"

If they now have a better understanding, you can move forward to Mapping.

If they still have a very poor understanding, you may need to plan a follow-up visit with someone else present who can help them understand.

➢ ***Even though it needs to be completed, it is futile to continue unless they can voice some level of understanding.***

Expect Emotion

REMAP

Talking about their illness may be very hard for them, especially if there is new information regarding a decline…*you will likely have emotions*. Tend to the emotion before moving on, or the rest of the conversation may not be successful.

Pause to allow time for emotion.

Be sure they are emotionally ready to be able to have a successful discussion.

If they are not ready for that discussion, acknowledge that and set up a follow-up plan.

Respond to the emotion by acknowledging it and providing empathetic responses.

"I can see you are very concerned about this."

- *Most of the time, they will start talking more after you say something like this.*

An emotional response may come out as a question.

"Are you just giving up on me?"

"Are you sure there is nothing else that can be done?"

Empathetic Responses

REMAP

“I can’t imagine how you must feel.”

“This really helps me understand what has been going on with you.”

“I really admire your…*(faith, strength, commitment, thoughtfulness, love)*…

for/to your family.”

“Could you say more about what you mean when you say, *‘I don’t want to give up, I am hoping for a miracle.’*?”

“I wish the situation were different.”

“In this situation, some people may feel…. (angry, scared, sad, upset).”

“Can you say more about that?”

Mapping

REMAP

Map out what is important to the patient by learning what matters most to them

before deciding on a plan of care.

- Explore what they do for enjoyment and their values and beliefs.

  "What gives life meaning?"

  "Do you have any beliefs or values that may influence medical decisions?"

  You may simply ask what life is like outside of the hospital for them.

This can be a difficult conversation to start if their illness already limits their functional status.

"As you think towards the future, what concerns you?"

"Knowing time may be limited, what things are most important to you?"

➢ ***This is where you can gain valuable information to assist with the goals of care conversation.***

Mapping

REMAP

Explore experiences with past illness with someone close to them.

"Tell me briefly about any experiences you have had with family or friends who became seriously ill or injured."

- **May facilitate thoughts they have regarding their future.**

➢ ***This information is often helpful during goals of care discussions.***

Role Play: Mapping

Mapping – Explore Goals for a sudden decline in QOL

REMAP

Begins transition to Treatment Preferences and possibly, Goal of Care conversation.

Transition the conversation by linking the information they have shared to this phase of the conversation.

Opens opportunities for the individual to talk about acceptable and unacceptable outcomes.

Imagine this situation: *"A sudden event, such as a MVA or stroke left you unable to care for yourself. Your care team believes that it is very unlikely that you will recover to know who you are or who you are with?"*

Confirm understanding of the situation.

"In this situation, would you want life-sustaining treatment continued or initiated? Either way, you will still get the care you need to keep you comfortable."

Mapping - Explore understanding of CPR

REMAP

Normalize the conversation.

Assure individuals understand you are talking about a situation in which their heart and breathing have stopped – death has occurred.

Address any misconceptions or concerns.

Most people believe CPR is successful over 50% of the time. It is important to explore their understanding and educate them so they can make an informed consent.

“I would like to talk about CPR, as decisions about CPR are one of the most commonly asked questions someone has to make. Is that okay?”

“What do you understand about CPR?”

“What has your doctor told you about CPR?”

“What do you know about the success rate of CPR?”

Role Play: Understanding of CPR

CPR Education

Ask permission to share general education on CPR.

Education should include:

- Reinforcing heart & breathing have stopped – ***Death has occurred***
- Components of CPR
- Success rates
- Possible outcomes
- How wishes are shared via code status

- **Components of CPR**
  - Chest compressions, defibrillation, cardiac arrest medications, and assistance with breathing
- **Success rates**
  - In-hospital: 20-25%
  - Out of hospital: 5-10%
  - Advanced Age: 5%
  - Advanced Illness: 1-2%
- **Possible outcomes**
  - Broken ribs, organ damage
- **How wishes are shared via code status**
  - Full, DNR, Comfort Measures
  - Clarify wishes for DNI

Polling Question #7

Select all statements that are <u>TRUE</u> related to Do Not Resuscitate (DNR) orders: *(select all that apply)*

- If the patient has a DNR order, they should not be transferred to the ICU.
- If the patient has a DNR order, they should not receive aggressive treatment or testing such as cardioversion, blood transfusions, TEE, PET scan, etc.
- If the patient has a DNR order, they should not be intubated for difficulty breathing.
- If the patient has a DNR order, they should not receive chemotherapy or radiation.
- If I discuss DNR with my patient, they believe I am giving up hope for recovery.
- If the patient has DNR wishes documented in an Advance Medical Directive, this will be followed by EMS and other health care workers.

Out-of-Hospital Do Not Resuscitate (OOH-DNR) Order

If a patient wishes to have a DNR order, the following education is needed to ensure this wish is honored:

- *DNR wishes must be shared on every admission to a medical facility.*
- *A portable medical order will need to be completed:*
  - **MI-POST** *(discussed later)*
  - **Out-of-Hospital (OOH-DNR) order** *– see handouts for examples*
    - Signed and dated by:
      - ✓Patient & two witnesses
      - ✓Physician

➢ ***Must include:***

"THIS FORM WAS PREPARED PURSUANT TO, AND IS IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT."

Mapping- Gradual Decline vs Sudden Decline

REMAP

Patients may experience a gradual or sudden decline, and conversations discussing both paths are appropriate in ACP to assist with future decision-making that may occur.

- ***The best thing to do when addressing these topics is to normalize the conversation.***

"We discuss possibilities with all our patients to be sure what we are caring for you in the way you wanted to be cared for in any situation."

"Our goal is to make sure you get the care that you want in any situation that might come up."

"Would it be ok if we talked about a few scenarios that might come up so that I can make sure we have the appropriate things in place to ensure your wishes are abided by during those situations?"

"Unfortunately, death is something everyone will go through at some point in life. It is a scary and sensitive topic, but if we address it before we have a crisis, it makes it easier on you and your family."

Mapping- Explore Goals for a gradual decline in QOL

REMAP

" Right now, we have talked about your overall goals, and you have stated that you want to continue with Palliative Chemo and Radiation for your Cancer to help prolong and improve your quality of life. We will work together to include this in your plan of care."

"We know things can change rapidly, and we want to be able to abide by your wishes in any given situation. We want to have these conversations early and up front before a crisis occurs. So, I would like to talk more about what your plan might be in some different situations. Would that be okay?"

"What is an acceptable quality of life for you?"

"What are the things that are non-negotiable for you to be able to do?"

"There may come a time when you reach that quality of life that is not acceptable for you. Have you thought about what that may look like?"

"If someone told you your time is very limited, and you are at EOL, what would you want that to look like?"

"If you knew you had days to weeks to live, would you want to spend that time in the hospital getting aggressive care, or would you want to spend that time at home comfortably?"

Aligning with Patient Values & Beliefs

REMAP

Summarize the conversation.

- **Assures you understood correctly.**
- **The patient feels like they have been heard.**
- **Facilitates trust.**
- **Clarify fears**

"As I listen to what you have said it seems that _____ is most important to you, did I get this right?"

Aligning by Summarizing Conversation

REMAP

"Given what you have shared, it sounds like, for right now, you want to continue your treatments as long as you are still able to get around and care for yourself and spend time with your extended family. If your quality of life gets to a point where you are bedbound and unable to care for yourself any longer, you do not want to continue treatments and want to focus on being comfortable."

"Does that sound correct?"

"My recommendation in this situation is that we will continue to provide you with treatments as long as you have the acceptable quality of life you have shared with me. Once your quality of life is below that acceptable level, we will transition our focus to provide you comfort and dignity. The best way to do this is to get hospice in the home arranged to help support that portion of your journey to ensure all your needs are met, and you are comfortable."

Aligning with Patient Values & Beliefs

REMAP

Patient

“I am really tired of being in the hospital. I am scared that my breathing is getting worse and that I am going to feel like I am suffocating.

I really don’t want to be kept alive on machines, but I am scared about what might happen if I don’t. I also really miss spending time with my family.”

Clinician

“So, from what you’re telling me, ideally, you would like to spend more time out of the hospital and more time at home with your family. You also want to make sure that your shortness of breath is well controlled, and you do not want to be kept alive on a machine if it is your time.

Does that seem right?”

Purpose a Plan

REMAP

Transition to completion of document, as well as an OOH-DNR order or MI-POST if indicated.

"You have shared some important information today regarding your future treatment. Are you ready to complete a document?"

Transition to Goals of Care recommendations.

"Would it be okay if I made a recommendation?"

Focus on:

- *What can be achieved.*
- *What might be possible.*
- *Discuss what not to do as it may not help meet their goals.*

Follow with an open-ended question.

"What do you think of this plan?"

Communication Pearls

- **Always use “I” communication**
- ***“I wish I had better results to share”***
- **Tell me more (if you ever don’t know what to say),** *“Tell me more…”*
- ***Make sure you clarify what a patient is asking before answering.***
- *“Has anyone ever talked to you about what to expect?”*
- *“What scares you the most?”*
- **If you get stuck continue to explore until you get where you need to be.**

- **Be supportive (many times people just need to feel like they are not alone) even though you may not have good news they will feel better if they know they will have support.**
- **After that conversation make sure you answer all questions.**
- **Address any elephants in the room.**
- **Also, if patient is present make sure you are talking with them *and not about them.***

“Would it be ok if I gave you a recommendation?”

“Given what you have told me is most important, there is a lot we can do to help. First, we will focus on getting your shortness of breath controlled. We will then get you services in your home to help with this and make sure you can stay home and spend as much time with family as possible. I would recommend from what you have told me about your long-term goals that if heart or breathing stops we would not attempt resuscitation. I do not think that this will help you reach your goals.”

“Does this sound right?”

“Here is what we can do moving forward to make sure your goals are met, and we abide by your wishes. We will adjust some medications to help with your shortness of breath. We will create an order for outside of the hospital called a MI-POST. We will get you assistance to create an advance directive to document your wishes.”

Case scenario

You are meeting with Fred in the palliative care clinic. Fred had advanced COPD, SOB with minimal exertion, DM, and DDD limiting his mobility. He is currently on 4L O2 at home. He has lost 15 pounds in the past 6 months. Other than medical appointments, he has not left his home for 1 year due to severe dyspnea. Fred's wife and son are with him. You are meeting him for the first time.

After reviewing medical history, Fred says to you:

"Could I ask you…what is going to happen?"

Clinician Responses

“Could I ask you…what is going to happen?”

Expert Response:

“Let me make sure I understand. Do you mean what we will do today or what will happen in the future?” **Clarify what is being asked.**

Common good but not as great answers:

- *“We’ll do the best we can.”* - **Supportive, question remains ambiguous.**
- *“I think your COPD is getting worse, and you could end up in the hospital or even ICU.”* - **Factual but assumes the clinician knows what he is asking.**
- *“COPD will gradually get worse, and you might need a nursing home.”* - **A reasonable prediction, but he did not ask for this detail yet.**

CAPC.org/training/communication-skills…

“How long do I have to live?”

Expert response:

“That must be a hard question to ask. Tell me more about what you want to know: Are you interested in how long people with a similar diagnosis typically live? Or sometimes people are thinking about an important future event, like a wedding or anniversary?” **Explores more details on what the person may be looking for.**

Common good *but not as great answers*:

- *“It’s hard to predict with COPD.”* **Correct, but doesn’t clarify the intent of his question.**
- *“It’s probably around a year.”* **Correct, but doesn’t clarify the intent of his question. Doesn’t address variability for individuals.**
- *“You could live like this for a while.”* **Supportive, but avoids his concerns and fails to assess the type of information he wants.**

CAPC.org/training/communication-skills…

“Give it to me straight.”

Expert response:

“I will give you a best-case and worst-case scenario. Most patients fall somewhere in between. Some patients can live for five years; that’s the best case. The worst case could happen at any time: if you get a bad infection like PN, the risk of death is high. We will do everything we can to reduce those risks for you.” **Gives the best and worst-case scenarios.**

Common good but not as great answers:

- *“The average time a person with advanced COPD lives is a year.”* – **Accurate but does not prepare the patient for variability.**
- *“I’ve seen people live for a few years with this.”* - **Best case scenario represents an extreme outlier but does not promote awareness of realistic prognosis.**
- *“Your condition is precarious – you could end up in the hospital needing help for your breathing.”* - **Does not address his request for a timeline.**

CAPC.org/training/communication-skills…

5 Minute Break

Polling Question #8

Have you seen or completed a MI-POST?

- Yes
- No

Do you discuss the out-of-hospital DNR order with your patients?

- Yes
- No

Michigan Physician Orders for Scope of Treatment (MI-POST)

What is MI-POST?

- An order for honoring patients' wishes for life-sustaining treatment.
- Part of the Advance Care Planning process for adult patients with serious illnesses.
- Michigan Law passed in November 2017, the initial MI-POST order was available to pilot counties, and the finalized MI-POST order was made accessible statewide in 2022.
- Optional portable order for adults with advanced illness or frailty whose life expectancy is approximated at 12 months outside of the acute setting.
- Actionable by Emergency Medical Services (EMS) personnel ONLY.
- The approved Michigan MI-POST form must be used; use of other states' forms or the national POLST form requires EMS to contact the Medical Control Authority for guidance while life-sustaining interventions are initiated.

What's the Difference?

Out-of-Hospital DNR Order

- Available to any Adult, regardless of diagnosis or life expectancy; minors with advanced illness
- Signed by the competent patient in the presence of two witnesses
  - Activated Patient Advocate
  - Court-appointed Legal Guardian
  - Parent of minor
- **Signed by a physician ONLY**
- **Actionable by EMS, physicians, nurses, and many other health professionals**
- For use outside of a hospital admission
- No expiration date
- Patient may revoke this order at any time

MI-POST

- Adults with Advanced Illness or Frailty whose life expectancy is estimated at 12 months
- Signed by the patient, no witnesses needed
  - Activated Patient Advocate
  - Court-appointed Legal Guardian
- **Signed by the attending health professional (physician, nurse practitioner, or physician's assistant)**
- **Actionable by EMS personnel ONLY**
- For use outside of acute care
- Expires after 12 months
- Patient may revoke this order at any time
- Must be reaffirmed when changing the level of care

Michigan Do Not Resuscitate Procedure Act MCL 333.1051-1067

333.1061 Determination by health professional.

Sec. 11.

(1) One or more of the following health professionals who arrive at a declarant's location outside of a hospital shall determine if the declarant has 1 or more vital signs, whether or not the health professional views or has actual notice of an order that is alleged to have been executed by the declarant or other person authorized to execute an order on the declarant's behalf:

- **(a) A paramedic.**
- **(b) An emergency medical technician.**
- **(c) An emergency medical technician specialist.**
- **(d) A physician.**
- **(e) A nurse.**
- **(f) A medical first responder.**
- **(g) A respiratory therapist.**
- **(h) A physician's assistant.**

(2) If the health professional determines under subsection (1) that the declarant has no vital signs, and if the health professional determines that the declarant is wearing a do-not-resuscitate identification bracelet or has actual notice of a do-not-resuscitate order for the declarant, subject to section 11a, the health professional shall not attempt to resuscitate the declarant.

(3) If the declarant is a minor child who is enrolled and located at a school, an individual who determines that the declarant is wearing a do-not-resuscitate identification bracelet or has actual notice of a do-not-resuscitate order for the declarant shall not attempt to resuscitate the declarant before a health professional described in subsection (1) arrives at the declarant's location.

History: 1996, Act 193, Eff. Aug. 1, 1996 ;-- Am. 2013, Act 155, Eff. Feb. 4, 2014 ;-- Am. 2017, Act 157, Eff. Feb. 6, 2018 ;-- Am. 2020, Act 363, Eff. Apr. 4, 2021

Michigan Physician Orders for Scope of Treatment MCL 333.5671-5685

333.5679 POST form; use as communication tool; treatment by emergency medical services personnel; exceptions; noncompliance by health professional or health facility.

Sec. 5679.

(1) In an acute care setting, a health professional who is treating the patient may use a completed POST form as a communication tool.

(2) Emergency medical services personnel shall provide or withhold treatment to a patient according to the orders on a POST form unless any of the following apply:

(a) The emergency medical services being provided by the emergency medical services personnel are necessitated by an injury or medical condition that is unrelated to the diagnosis or medical condition that is indicated on the patient's POST form.

(b) The orders on the POST form request medical treatment that is contrary to generally accepted health care standards or emergency medical protocols.

(c) The POST form contains a medical order regarding the initiation of resuscitation if the patient suffers cessation of both spontaneous respiration and circulation, and the emergency medical services personnel has actual notice of a do-not-resuscitate order that was executed under the Michigan do-not-resuscitate procedure act, 1996 PA 193, MCL 333.1051 to 333.1067, after the POST form was validly executed. As used in this subdivision, "actual notice" means that term as defined in section 2 of the Michigan do-not-resuscitate procedure act, 1996 PA 193, MCL 333.1052.

(d) The POST form has been revoked in the manner provided in this part and the emergency medical services personnel has actual notice of the revocation.

(3) If a health professional or health facility is unwilling to comply with the medical orders on a validly executed POST form because of a policy, religious belief, or moral conviction, the health professional or health facility shall take all reasonable steps to refer or transfer the patient to another health professional or health facility. If an adult foster care facility is unwilling to comply with the medical orders on a validly executed POST form for the reasons described in this subsection, the adult foster care facility shall take all reasonable steps to refer or transfer the patient to another adult foster care facility as provided in section 26c of the adult foster care facility licensing act, 1979 PA 218, MCL 400.726c.

History: Add. 2017, Act 154, Eff. Feb. 6, 2018

Popular Name: Act 368

MDHHS-5837, MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST) PATIENT AND FAMILY INFORMATION SHEET

Michigan Department of Health and Human Services (MDHHS)
(Revised 8-22)

What is a MI-POST?

- An optional, one-page, two-sided medical order with a person's wishes for care in a crisis.
- A part of the advance care planning process that includes choices about Cardiopulmonary Resuscitation (CPR), critical care, and other wanted care.
- A form that guides care only if the person cannot tell others what to do at that time.
- A completed form is signed by the patient/patient representative and the physician, nurse practitioner, or physician's assistant that gives medical advice and suggestions.
- A patient representative may fill out a MI-POST for the person if they are not able to make healthcare choices due to illness or injury.

Who has a MI-POST?

- An adult with advanced illness or frailty, such as advanced, life-threatening heart failure, who talks to a healthcare provider to help determine their choices in care.

Where can a MI-POST be found?

- A blank MI-POST can be found in care settings, including a provider's office, a health care facility or agency, or online.
- Completed forms belong to the person and are kept with the person wherever they live.
- Copies of the form can be given to family, friends, hospitals, and any other places the person wants, but the original stays with the person.

When can a MI-POST be changed?

- The form can be changed at any time by the person or the patient representative, verbally or in writing.
- The form must be revoked or reaffirmed by the patient or patient representative and the attending health professional under the circumstances below. The form must be revoked or reaffirmed within the timeframes outline below or it will be considered VOID.
  - One year from the date since the form was last signed or reaffirmed.
  - 30 days from a change in the patient's attending health professional or change in the patient's level of care, or care setting; or any unexpected change in the patient's medical condition.

How do I reaffirm or revoke a MI-POST?

- Reaffirming this MI-POST form indicates the person has no changes to their treatment choices. Reaffirming requires signatures with dating of reaffirmation on the second page of the form. The form provides space for one reaffirmation. If another reaffirmation is needed, a new MI-POST form should be completed.
- Revocation of this MI-POST form is required if treatment changes are desired. A new MI-POST form should be completed to reflect treatment changes. Write "REVOKED" over the signatures of the patient or patient representative; and the signature(s) of the Attending Health Professional, in Sections D and G, if used, on this MI-POST form. Initial and date the revocations.
  - Write "VOID" diagonally on both sides in large letters and dark ink.
  - Take reasonable action to notify Attending Health Professional, patient, patient representative, and care setting.

What do the types of Medical Interventions mean?

- **Comfort-Focused Treatment** – primary goal of maximizing comfort. Relieve pain and suffering through use of medication by any route, positioning, wound care, and other measures. Use oxygen, manual suction treatment of airway obstruction, and non-invasive respiratory assistance as needed for comfort. Food and water provided by mouth as tolerated. May involve transportation to the hospital if comfort needs cannot be met in current location.
- **Selective Treatment** – primary goal of treating medical conditions while avoiding burdensome measures. In addition to care described in comfort-focused treatment, use IV fluid therapies, cardiac monitoring including cardioversion, and non-invasive airway support (such as a CPAP or BiPAP) as indicated. DO NOT use advanced invasive airway interventions or mechanical ventilation. May involve transportation to the hospital. Generally, avoid intensive care.
- **Full Treatment** – primary goal of prolonging life by all medically effective means. In addition to care described in selective treatment, use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion, and other advanced interventions as medically indicated. Likely to involve transportation to the hospital. May include intensive care.

What if a section on MI-POST was previously left blank or incomplete?

- If a section was previously blank (Section A, B, or C) and is later completed, follow the procedures for reaffirming.

How is a MI-POST different from an advance directive?

- MI-POST tells what care to give and an advance directive tells who can speak (patient advocate) for the person if they are not able.
- An advance directive must be witnessed, the patient advocate must accept the role, and may or may not give information about wishes for care.

How is a MI-POST different from a Michigan Out of Hospital Do-Not-Resuscitate (DNR) order?

- A MI-POST is intended only for adults who may have advanced illness or frailty with a life expectancy of 1 year or less. A DNR order is intended for adults or minors with advanced illness with a life expectancy greater than 1 year.
- A DNR requires two (2) witness signatures. A MI-POST does not require witness signatures.

It is best for anyone with a MI-POST to also legally designate a patient advocate and talk to that person so that they will be prepared to speak on the person's behalf.

I have reviewed this information **BEFORE** signing a completed MI-POST.

Patient Name	Date of Birth
Patient Representative Name (if needed)	
Signature	Date

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

MDHHS-5836, MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)

Michigan Department of Health and Human Services (MDHHS)

(Revised 8-22)

HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary. This MI-POST form is void if Part 1 or Section D are blank. Leaving blank any section of the medical orders (Sections A, B, or C) does not void the form and is interpreted as full treatment for that section.

PART 1 – PATIENT INFORMATION

Patient Last Name | Patient First Name | Patient Middle Initial

Date of Birth (mm/dd/yyyy) | Date Form Prepared (mm/dd/yyyy)

Diagnosis supporting use of MI-POST

This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles, and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

PART 2 – MEDICAL ORDERS

Section A – Cardiopulmonary Resuscitation (CPR)

Person has no pulse and is not breathing. See MDHHS-5837 for further details.

- ☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
- ☐ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

Section B – Medical Interventions

Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.

- ☐ **Comfort-Focused Treatment**
  Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.
- ☐ **Selective Treatment**
  Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.
- ☐ **Full Treatment**
  Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

Section C – Additional Orders (optional)

Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, medically assisted provisions of nutrition, long-term life-support, medications, and blood products.

Send form with Patient whenever transferred or discharged.

Section D – Signature of Attending Health Professional

My signature below indicates that these orders are medically appropriate given the patient's current medical condition, reflect to the best of my knowledge the patient's goals for care, and that the patient (or the patient representative) has received the information sheet.

Print Name | Date

Signature | Phone Number

Print Name of Collaborating Physician | Phone Number

Section E – Signature of Patient or Patient Representative

My signature indicates I have discussed, understand, and voluntarily consent to the medical orders on this MI-POST form. I acknowledge that if I am signing as the patient's representative, these decisions are consistent with the patient's wishes to the best of my knowledge.

- ☐ Patient
- ☐ Patient Advocate/Durable Power of Attorney for Health Care (DPOAHC)
- ☐ Court-Appointed Guardian

Print Name of Patient | Print Name of Patient Representative

Signature | Date

Information of Legally Authorized Representative

Complete this section if this MI-POST form was signed by a Patient Advocate/DPOAHC or Court-Appointed Guardian.

Address | City | State | Zip Code

Phone Number | Alternate Phone Number

Section F – Individual Assisting with Completion of MI-POST Form

Print Preparer's Name | Title | Date

Preparer's Signature | Organization | Phone Number

Section G – To Reaffirm or Revoke this Form

This MI-POST form can be reaffirmed or revoked at any time, verbally or in writing. See MDHHS-5837 for further details on reaffirmation or revocation. **If this document is revoked or is not reaffirmed, and a new form is not completed, full treatment and resuscitation will be provided.**

Healthcare Provider Name/Collaborative Physician (if applicable) | Healthcare Provider Signature

Patient/Representative Name | Patient/Representative Signature | Reaffirmation Date

Send form with Patient whenever transferred or discharged.
HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary.

MI-POST Walkthrough

The next several slides detail different portions of the MI-POST form

MI-POST Part 1: Patient Information

MDHHS-5836, MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)

Michigan Department of Health and Human Services (MDHHS)

(Revised 8-22)

HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary. This MI-POST form is void if Part 1 or Section D are blank. Leaving blank any section of the medical orders (Sections A, B, or C) does not void the form and is interpreted as full treatment for that section.

PART 1 – PATIENT INFORMATION

Patient Last Name	Patient First Name	Patient Middle Initial

Date of Birth (mm/dd/yyyy)	Date Form Prepared (mm/dd/yyyy)

Diagnosis supporting use of MI-POST

This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles, and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

MDHHS
Michigan Department of Health & Human Services

MI-POST Part 2, Sections A-C: Medical Orders

PART 2 – MEDICAL ORDERS

Section A – Cardiopulmonary Resuscitation (CPR)

Person has no pulse and is not breathing. See MDHHS-5837 for further details.

- ☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
- ☐ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

Section B – Medical Interventions

Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.

- ☐ **Comfort-Focused Treatment**
  Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.
- ☐ **Selective Treatment**
  Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.
- ☐ **Full Treatment**
  Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

Section C – Additional Orders (optional)

Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, medically assisted provisions of nutrition, long-term life-support, medications, and blood products.

Send form with Patient whenever transferred or discharged.

MDHHS
Michigan Department of Health & Human Services

Section A:
Cardiopulmonary Resuscitation

Section A – Cardiopulmonary Resuscitation (CPR)

Person has no pulse and is not breathing. See MDHHS-5837 for further details.

- ☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
- ☐ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

MDHHS
Michigan Department of Health & Human Services

Section B:
Medical Interventions

Section B – Medical Interventions

Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.

☐ **Comfort-Focused Treatment**

Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.

☐ **Selective Treatment**

Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.

☐ **Full Treatment**

Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

MDHHS
Michigan Department of Health & Human Services

Section B: Dependent on A

Section A – Cardiopulmonary Resuscitation (CPR)

Person has no pulse and is not breathing. See MDHHS-5837 for further details.

- [x] Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
- [ ] DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

If elect Attempt Resuscitation/CPR in A, must choose Full Treatment in B

Section B – Medical Interventions

Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.

- [ ] **Comfort-Focused Treatment**
  Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.
- [ ] **Selective Treatment**
  Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.
- [x] **Full Treatment**
  Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

MDHHS
Michigan Department of Health & Human Services

Section B: Dependent on A

Section A – Cardiopulmonary Resuscitation (CPR)

Person has no pulse and is not breathing. See MDHHS-5837 for further details.

- ☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
- ☒ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

If elect DO NOT Attempt Resuscitation/CPR in A, can elect any treatment in B

Section B – Medical Interventions

Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.

☒

Pick One

- ☐ **Comfort-Focused Treatment**
  Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.
- ☐ **Selective Treatment**
  Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.
- ☐ **Full Treatment**
  Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

MDHHS
Michigan Department of Health & Human Services

Section C:
Additional Orders

Section C – Additional Orders (optional)
Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, medically assisted provisions of nutrition, long-term life-support, medications, and blood products.

MDHHS
Michigan Department of Health & Human Services

MI-POST Part 2, Sections D-E: Signatures

Section D – Signature of Attending Health Professional

My signature below indicates that these orders are medically appropriate given the patient's current medical condition, reflect to the best of my knowledge the patient's goals for care, and that the patient (or the patient representative) has received the information sheet.

Print Name	Date

Signature	Phone Number

Print Name of Collaborating Physician	Phone Number

Section E – Signature of Patient or Patient Representative

My signature indicates I have discussed, understand, and voluntarily consent to the medical orders on this MI-POST form. I acknowledge that if I am signing as the patient's representative, these decisions are consistent with the patient's wishes to the best of my knowledge.

☐ Patient ☐ Patient Advocate/Durable Power of Attorney for Health Care (DPOAHC)
☐ Court-Appointed Guardian

Print Name of Patient	Print Name of Patient Representative

Signature	Date

Information of Legally Authorized Representative

Complete this section if this MI-POST form was signed by a Patient Advocate/DPOAHC or Court-Appointed Guardian.

Address	City	State	Zip Code

Phone Number	Alternate Phone Number

MDHHS
Michigan Department of Health & Human Services

Section D: Signature of Attending Health Professional

Section D – Signature of Attending Health Professional

My signature below indicates that these orders are medically appropriate given the patient's current medical condition, reflect to the best of my knowledge the patient's goals for care, and that the patient (or the patient representative) has received the information sheet.

Print Name	Date
Signature	Phone Number
Print Name of Collaborating Physician	Phone Number

MDHHS
Michigan Department of Health & Human Services

Section E: Signature of Patient or Patient Representative

Section E – Signature of Patient or Patient Representative

My signature indicates I have discussed, understand, and voluntarily consent to the medical orders on this MI-POST form. I acknowledge that if I am signing as the patient's representative, these decisions are consistent with the patient's wishes to the best of my knowledge.

☐ Patient ☐ Patient Advocate/Durable Power of Attorney for Health Care (DPOAHC)
☐ Court-Appointed Guardian

Print Name of Patient

Print Name of Patient Representative

Signature

Date

Information of Legally Authorized Representative

Complete this section if this MI-POST form was signed by a Patient Advocate/DPOAHC or Court-Appointed Guardian.

Address

City

State

Zip Code

Phone Number

Alternate Phone Number

MDHHS
Michigan Department of Health & Human Services

Section F: Individual Assisting w/ Completion of MI-POST form

Section F – Individual Assisting with Completion of MI-POST Form		
Print Preparer's Name	Title	Date
Preparer's Signature	Organization	Phone Number

Section G: To Reaffirm or Revoke this Form

Section G – To Reaffirm or Revoke this Form

This MI-POST form can be reaffirmed or revoked at any time, verbally or in writing. See MDHHS-5837 for further details on reaffirmation or revocation. **If this document is revoked or is not reaffirmed, and a new form is not completed, full treatment and resuscitation will be provided.**

Healthcare Provider Name/Collaborative Physician (if applicable)	Healthcare Provider Signature

Patient/Representative Name	Patient/Representative Signature	Reaffirmation Date

Send form with Patient whenever transferred or discharged.
HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary.

MDHHS
Michigan Department of Health & Human Services

Rules for Reaffirming or Revoking

- In the following circumstances, **must** reaffirm/revoke:
  - One year from the date last signed or reaffirmed.
  - Thirty days from a change in:
    - Attending health professional.
    - Patient's place of care, level of care, or care setting.
    - Unexpected change in medical condition.

- Can be reaffirmed or revoked by the patient or patient representative at any time, in any manner.

MDHHS
Michigan Department of Health & Human Services

Reaffirming the MI-POST

- Date of reaffirmation.
- Must be signed by:
  - Attending health professional.
  - Patient or patient representative.
- If previously blank section completed → reaffirm.
- Cannot change previously completed section → must complete new form.

MDHHS
Michigan Department of Health & Human Services

Revoking the MI-POST

- Attending health professional, the patient, or the patient's patient advocate or court-appointed guardian writes **"revoked"** over the most recent signatures.

- The individual revoking the form writes **"void"** in large, bold ink diagonally across both sides of the form.

- Patient or patient representative must notify at least one:
  - Attending health professional.
  - Health professional treating patient.
  - Health facility responsible for the medical treatment of the patient.

MDHHS
Michigan Department of Health & Human Services

Compliance with MI-POST Form

- **EMS will treat patients according to orders on the MI-POST unless:**
  - Services provided result from an injury or medical condition unrelated to the diagnosis or medical condition on the patient's MI-POST.*
  - Valid MI-POST says to resuscitate and an Out-of-Hospital DNR was executed ***AFTER*** the MI-POST.
  - Valid MI-POST revoked.

➢ *Consider an out-of-hospital DNR for patients who want a DNR regardless of diagnosis.*

MDHHS
Michigan Department of Health & Human Services

Scenario 1: **Edward's MI-POST** in practice

Scenario 1

Edward

A few months after the execution of Edward's MI-POST with his attending health professional, his nurse practitioner, Edward is at home and experiences shortness of breath and EMS was called.

Upon arrival Edward is nonresponsive and has no pulse.

EMS professionals were unable to determine if the diagnosis of CHF was the precursor to the event and CPR was initiated. This was not the care that he desired, and Edward was subsequently transferred to the ED, where he continued to receive treatment that was not in-line with his wishes.

In practice, the Michigan MI-POST is not structured to support the realities of end-of-life care. In this scenario, EMS providers were unable to determine if his shortness of breath is connected to his diagnosis of CHF and defaulted to full treatment, including CPR.

The MI-POST Advisory Committee has identified several key recommendations to increase the efficacy and effectiveness of the MI-POST form.

MDHHS Final Report with Recommendations

Created in partnership with the MI-POST Advisory Committee

- **Highlights the following concerns:**
  - MI-POST is actionable by EMS personnel ONLY
  - Requiring a diagnosis on the order may cause confusion for EMS and concern that only the diagnosis listed corresponds to the actions taken
  - 12-month expiration date and the need to create a new MI-POST
  - The requirement for reaffirming the MI-POST when the patient changes level of care is burdensome

MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Questions?

References

CAPC (Center to Advance Palliative Care). www.capc.org

Carney, M.T., Williams, M., Zhang, M., Kozikowski, A., Dolgin, J., …Pekmezaris, R. (2020). Impact of community health conversation upon advance care planning attitudes and preparation intentions. Retrieved from https://www.tandfonlin.com/doi/abs/j10.1080.02701960.2020.1739670

Cooperation. communication. collaboration. National Coalition For Hospice and Palliative Care. (n.d.). Retrieved April 3, 2023, from https://www.nationalcoalitionhpc.org/

Curtis, J. (2021). Three Stories About the Value of Advance Care Planning. JAMA;326(21):2133–2134. doi:10.1001/jama.2021.21075

Dahlin, C., & Lynch, M. T. (2013). Core curriculum for the Advanced Practice Hospice and Palliative Registered Nurse. Hospice and Palliative Nurses Association.

DeMartino, E., Dudzinski, D., Doyle, C., Sperry, B., Gregory, S., Siegler, M., Sulmasy, D., Mueller, P., Kramer, D. (2017). Who Decides When a Patient Can't? Statutes on Alternate Decision Makers. N Engl J Med. Apr 13;376(15):1478-1482. doi: 10.1056/NEJMms1611497. PMID: 28402767; PMCID: PMC5527273.

Estates and Protected Individuals Code Act 386 of 1998, Michigan Compiled Laws 700.5506-5520. https://www.legislature.mi.gov/Laws/MCL?objectName=mcl-700-5506

H.R.5067 - 101st Congress (1989-1990): Patient Self Determination Act of 1990. (1990, November 5). https://www.congress.gov/bill/101st-congress/house-bill/5067

Hook, C., Mueller, P. (2005). The Terri Schiavo Saga: The Making of a Tragedy and Lessons Learned, Mayo Clinic Proceedings, Volume 80, Issue 11, Pages 1449-1460, ISSN 0025-6196, https://doi.org/10.4065/80.11.1449.

Kias, L.M., Frutig, M, Bezerra, M.R., Barra, W.F., Castro, L., & Rego, F. (2023). Advance Care Planning and Goals of Care Discussion: Barriers from the Perspective of Medical Residents. Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC9961136/. doi: 10.3390/ijerph20043239

Michigan Do-Not-Resuscitate Procedure Act 193 of 1996. mcl-Act-193-of-1996.pdf

Michigan Physician Orders for Scope of Treatment, MDHHS website. MI-POST

Michigan Physician Orders for Scope of Treatment Act 154 of 2017. 2017-LSB-0154-A.pdf

Mohan, D., Sacks, O., O'Malley, J., Rudolph, M., …Barnato, A. E. (2020). A new standard for advance care planning (ACP) conversation in the hospital: Results from a Delphi Panel. Retrieved from: http://link.springer.com/article/10.1007/511606-020-06150-0

Morrison, R., Meier, D., Arnold, R. (2021). What's Wrong With Advance Care Planning? JAMA, 326(16):1575–1576. doi:10.1001/jama.2021.16430.

Navin, M. C., Brummett, A. L., & Wasserman, J. A. (2022). Three Kinds of Decision-Making Capacity for Refusing Medical Interventions. The American Journal of Bioethics, 22(11), 73–83. https://doi.org/10.1080/15265161.2021.1941423.

Nedjat-Haiem, F., Hirsch, J., Currin-McCulloch, J., Lundquist, M. (2023). Social workers' perspectives about advance directives: A qualitative study, Patient Education and Counseling, Volume 111, 107691, ISSN 0738-3991, https://doi.org/10.1016/j.pec.2023.107691.

Needle, J. (2023). Standard for Surrogate Decision Making [Webinar] University of Minnesota Center for Bioethics. https://bioethics.umn.edu/events/standards-surrogate-decision-making.

Prince-Paul, M. & DeFranco (2017). Upstreaming and Normalizing Advance Care Planning Conversations – A Public Health Approach. Retruieved from http://www/,d[o/cp,2076-328X/7/2/18. June 2022.