ADVANCE CARE PLANNING:
Empowering you to make informed choices

Barry Platnick, MD, FACS, MSPC
Medical Director for Palliative Care, Boulder Community Health
Trauma and Acute Care Surgeon BCH/Denver Health
Assistant Professor of Surgery CUSOM
Barry.Platnick@bch.org

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MY BACKGROUND:

- Trauma Surgeon and Surgical Intensivist for 35 years – board certified in both
- Previous Trauma Medical Director and SICU Director at Denver Health Medical Center

Surgeon → **Palliative Care**

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OBJECTIVES:

- What advance care planning is and why is it important.
- What documents are used to record your wishes.
- Importance of a **chosen** healthcare proxy.
- Explore ways to talk with friends, family, and healthcare providers about your future care.

A little bit of boring definitions, nuts, and bolts, and hopefully some real food for thought.


World Mortality Rate
100%
1800
100%
1900
100%
1950
100%
2000
100%
2015

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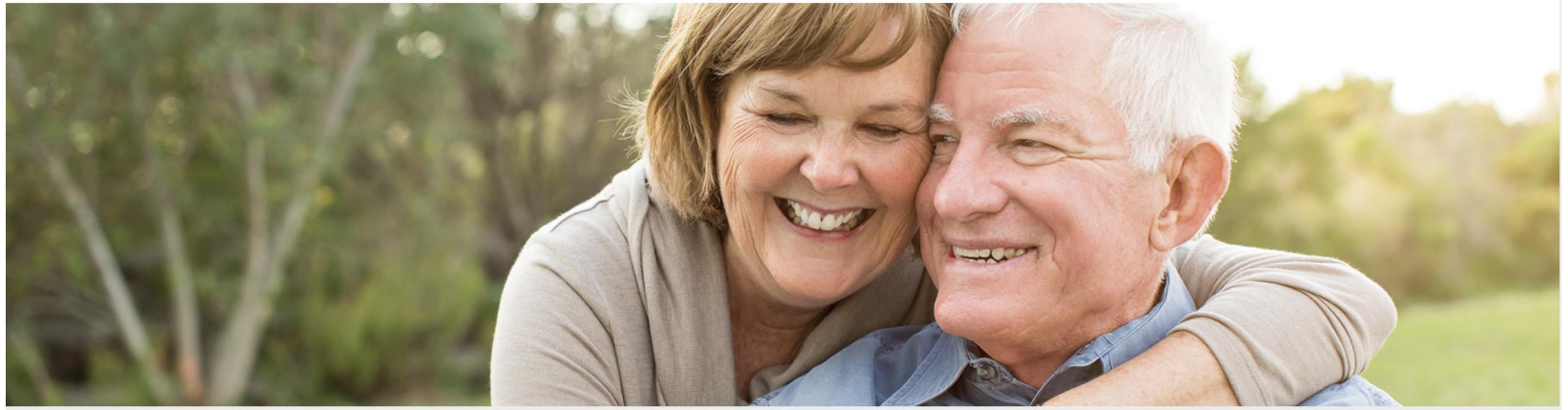

Patient & Visitors > Patient Services > *Advance Care Planning*

Advance Care Planning

Advance Care Planning is the process that allows you to make decisions about future

Patient Services

BCH.ORG

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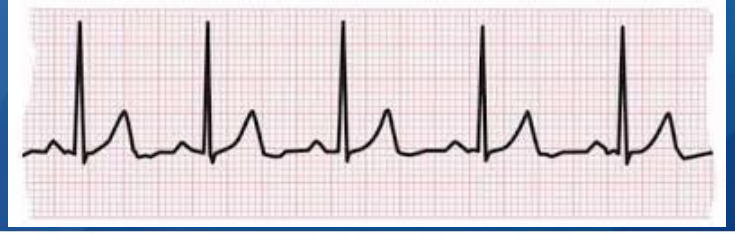
WHAT IS ADVANCE CARE PLANNING?

- It's a ***process*** that results, hopefully, in documents and clarity.
- Designed to help you think about, discuss, and document your healthcare preferences.
- Meant to ensure that your wishes are respected, even if you can't communicate them.
- Includes tools like living wills, medical power of attorney (MDPOA), and MOST forms.

WHAT ARE ADVANCE DIRECTIVES?

- Advance directives are ***documents.***
- **Living will –** What you would or would not want if you can't say so yourself.
- **MDPOA** - Who you want making decisions for you if you can't do so yourself.



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CASE OVERVIEW — CARDIAC ARREST WITHOUT ADVANCED CARE PLANNING

- 82-year-old male with multiple chronic illnesses (CHF, COPD, diabetes).
- Found unresponsive at home; brought to the Emergency Department (ED) in cardiac arrest.
- No advance directives (***MOST***, CO CPR, living will) or MDPOA available.
- In-town family arrives shortly after resuscitation begins — visibly distraught, uncertain about patient's wishes.
- ED team initiates ACLS protocol per standard of care.
- Family asks if "everything" should be done but provides conflicting input.

- **Ultimately, he is unable to be resuscitated.**

WHY ADVANCE CARE PLANNING MATTERS

- Can provide peace of mind for you and loved ones.
- Reduces confusion and conflict during emergencies.
- Aligns medical care with your personal values and beliefs.

WHAT IS AN "ACCEPTABLE LIFE" VARIES GREATLY….

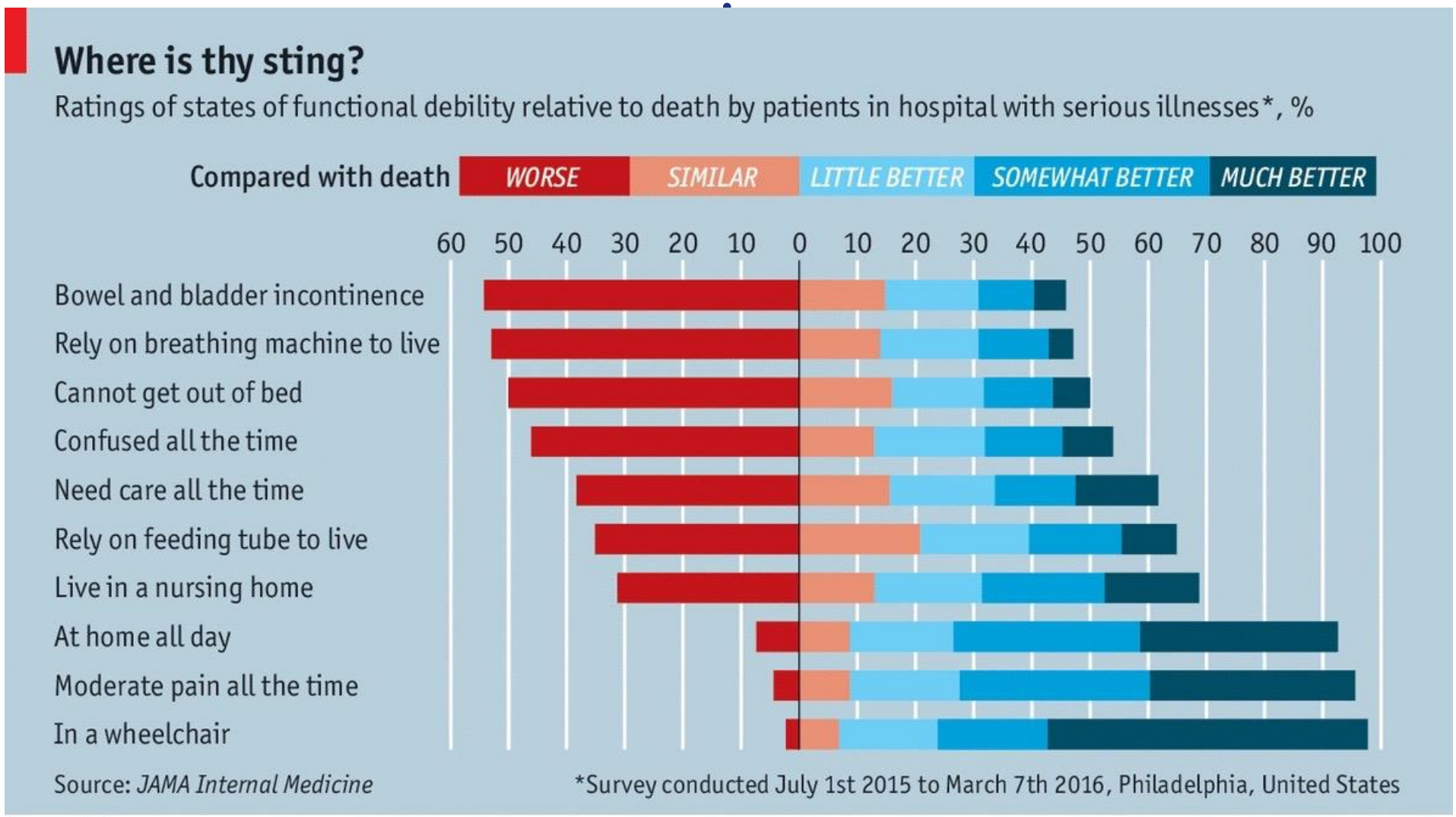


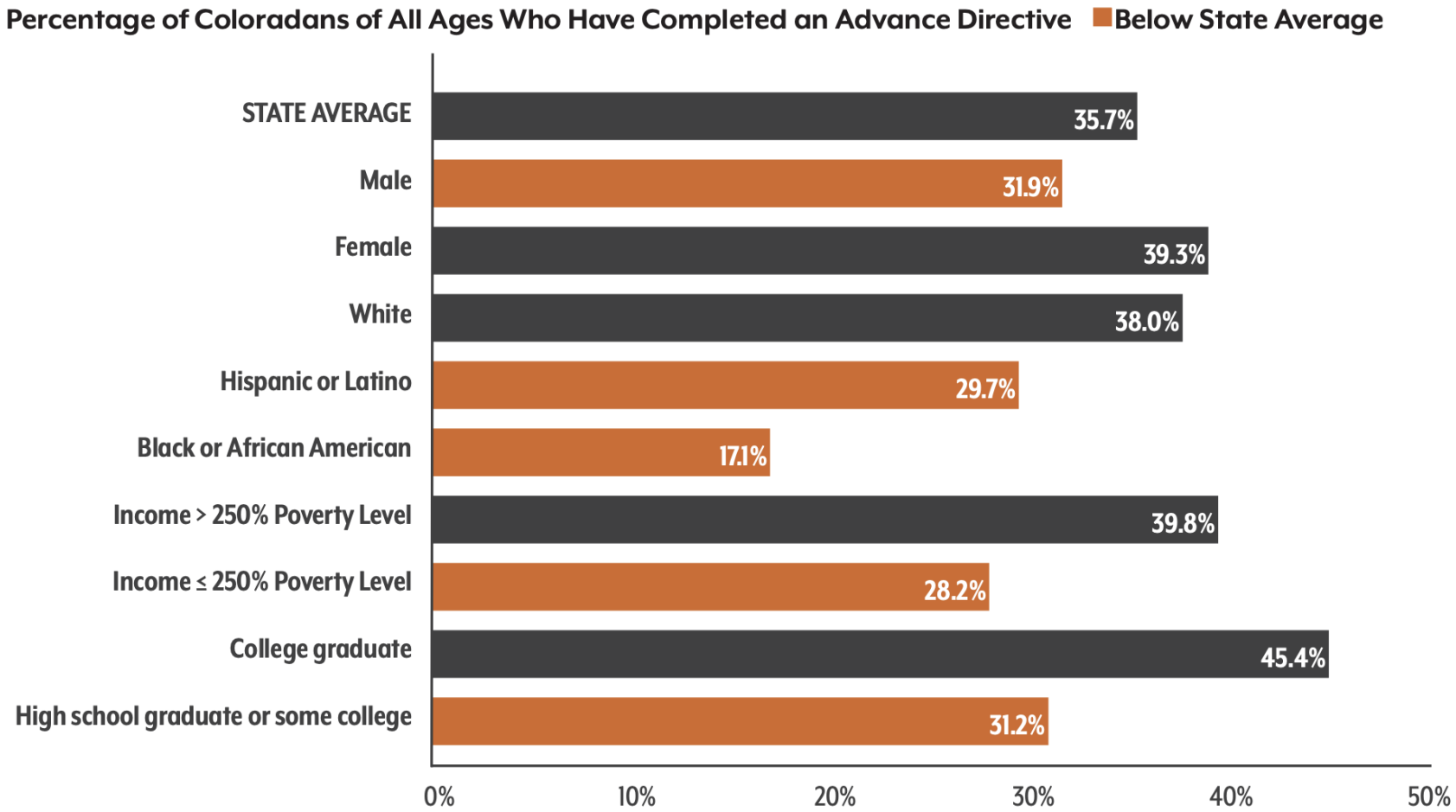
Table 1: Comparing Colorado to the U.S.

Percentage of people with advance directives

Older adults	66.4%	45.6%
Younger adults	29.3%	31.6%
All ages	35.7%	36.7%

Source: Colorado Health Access Survey, 2017; Health Affairs, 2017

Table 2: Completion of Advance Directives Varies by Demographic



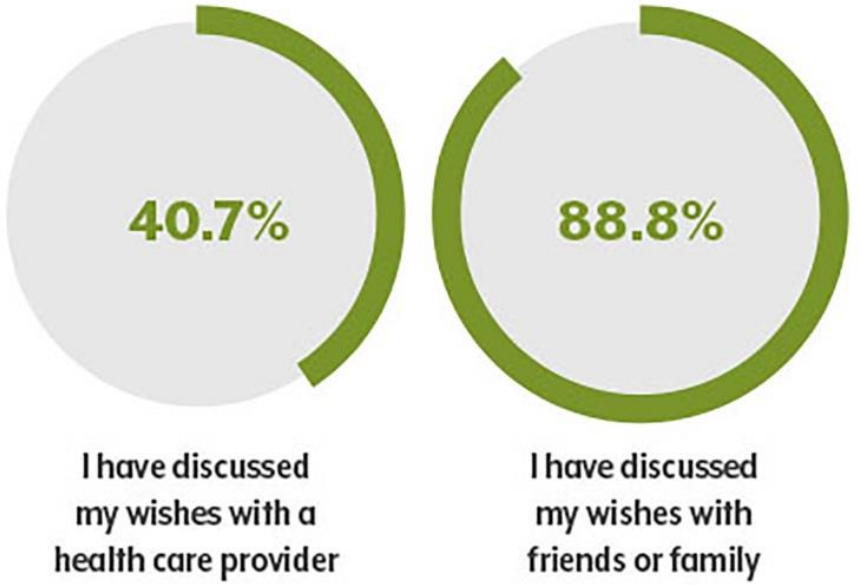
Source: Colorado Health Access Survey, 2017

Table 3: Factors That Have Little Impact On Advance Directive Completion

Percentage of Colorado Adults Who Have Completed an Advance Directive	
Urban	37.1%
Rural	35.4%
Good or excellent health	35.9%
Fair or poor health	34.4%

Source: Colorado Health Access Survey, 2017

Figure 3: Discussions of End-of-Life Medical Care by Those with an Advance Directive



Note: For adults in good health, it is less pressing for them to discuss their wishes with a medical provider, so it is impossible to know whether 40.7 percent is low.

Source: Colorado Health Access Survey, 2017

LIVING WILL

- A document that outlines how you want your healthcare managed in the event that you are no longer able to make your own decisions.
- Commonly addressed situations/decisions include:
  - CPR
  - Ventilators
  - Pacemakers/ICDs
  - Artificial nutrition and hydration

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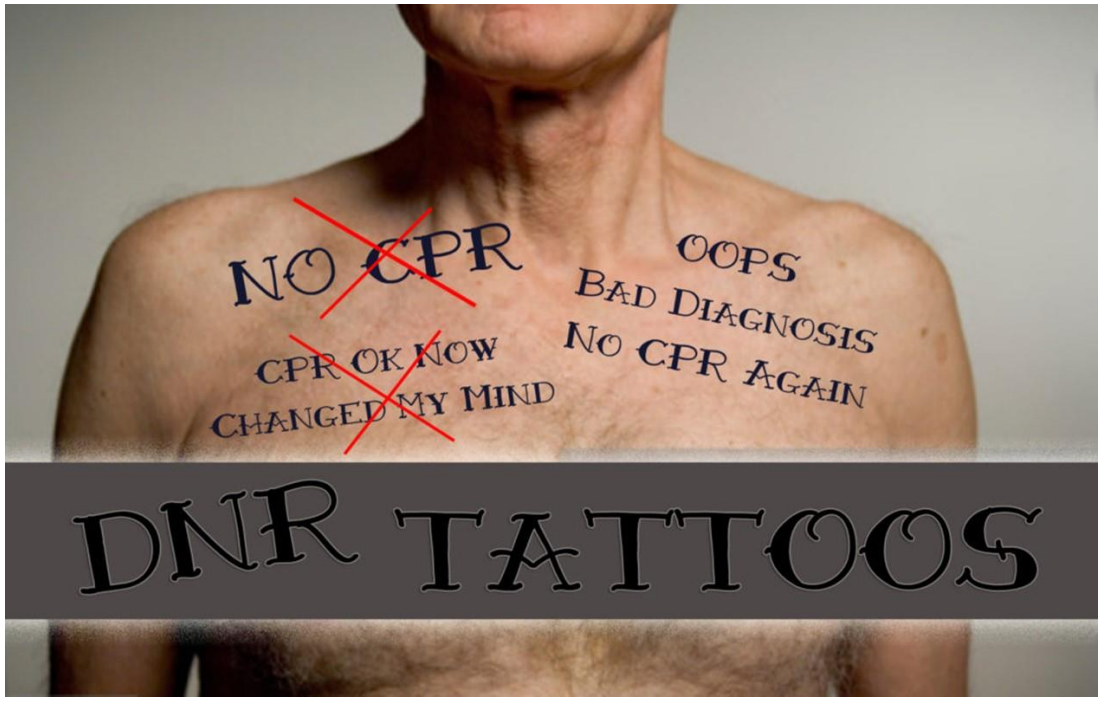
LIVING WILL -REQUIREMENTS

- You must be 18 years or older.
- Colorado law requires two unrelated witnesses to sign your living will.

  or…

- It must be notarized.



COLORADO CPR DIRECTIVE

Patient's or Authorized Agent's Directive to Withhold Cardiopulmonary Resuscitation (CPR)
This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2

Patient's Information

Patient's Name _____
(Printed Name)

If Applicable- Name of Agent/Legally Authorized Guardian/Parent of Minor Child _____
(Printed Name)

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Eye Color: _____ Hair Color: _____

Race Ethnicity : ☐ Asian or Pacific Islander ☐ Black, non-Hispanic ☐ White, non-Hispanic
☐ American Indian or Alaska Native ☐ Hispanic ☐ Other

If Applicable- Name of hospice program/provider: _____

Physician's Information

Physician's Name: _____
(Printed Name)

Physician's Address: _____

Physician's telephone: ( ) _____ Physician's Colorado License #: _____

Directive Attestation

Check **ONLY** the information that applies:

☐ Patient: I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.

☐ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child: I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that as a result of this directive, if the patient's heart or breathing stops or malfunctions, the patient will not receive CPR and may die.

☐ Tissue Donation: I hereby make an anatomical gift, to be effective upon my death of:
☐ Any needed tissues
The following tissues: ☐ Skin ☐ Cornea ☐ Bone, related tissues and tendons

I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardiopulmonary resuscitation in the event that my/the patient's heart or breathing stops or malfunctions. I understand that this directive does not constitute refusal of other medical interventions for my/the patient's care and comfort. If I/the patient am/is admitted to a health care facility, this directive shall be implemented as a physician's order, pending further physician's orders.

_____
☐ Signature of Patient
☐ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child

_____
Physician Signature

_____
Date

_____
Date

COLORADO MOST FORM

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

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

Legal Last Name		
Legal First Name/Middle Name		
Date of Birth		Sex
Hair Color	Eye Color	Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. (See additional instructions on page 2.)

A — Check one box only

CARDIOPULMONARY RESUSCITATION (CPR) ***Person has no pulse and is not breathing.***

☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation

NOTE: Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B.
When not in cardiopulmonary arrest, follow orders in Section B.

B — Check one box only

MEDICAL INTERVENTIONS ***Person has pulse and/or is breathing.***

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. Do not intubate. May use noninvasive positive airway pressure. Transfer to hospital if indicated. Avoid intensive care.

☐ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

Additional Orders: _____

C — Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION *Always offer food & water by mouth if feasible.*

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section *does not* imply any one of the choices—further discussion is required. *NOTE: Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

Additional Orders: _____

D

DISCUSSED WITH (check all that apply):
☐ Patient
☐ Agent under Medical Durable Power of Attorney
☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6))
☐ Legal guardian
☐ Other: _____

SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (*MANDATORY*)

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

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

Patient/Legal Decision Maker Signature (Mandatory)	Name (Print)	Relationship/ Decision maker status (Write "self" if patient)	Date Signed (Mandatory; Revokes all previous MOST forms)

Physician / APN / PA Signature (Mandatory)	Print Physician / APN / PA Name, Address, and Phone Number	Date Signed (Mandatory)
Colorado License #:		

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

Authority for this form and process is granted by C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment, enacted 2010.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

ADDITIONAL INFORMATION: *Please provide contact information below, in case follow up or more information needed.*

Patient Legal Last Name	Patient Legal First Name	Patient Middle Name (If any)	Patient Date of Birth

Primary Contact Person for the Patient	Relationship and/or MDPOA, Proxy, Guardian	Phone Number/email/Other contact information	

Healthcare Professional Preparing Form	Preparer Title	Phone Number/Email	Date Prepared

Patient Primary Diagnosis	Hospice Program (If applicable) /Address	Hospice Phone Number

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

For more information, please go to: www.coloradobioethics.org/comostprogram *

Completing the MOST form:

- MOST form may be downloaded from www.coloradobioethics.org/comostprogram and copied onto Astrobrights* "Terra Green" or "Vulcan Green" paper. This special paper is strongly encouraged because it is easily recognized but it is not required.*
- The form must be signed by a physician, advanced practice nurse, or physician assistant to be valid as medical orders. Physician assistants must include physician name and contact information. In the absence of a provider signature, however, the patient selections should be considered as valid, documented patient preferences for treatment.
- Verbal orders are acceptable with follow-up signature by physician, advanced practice nurse, or physician assistant in accordance with facility policy, but not to exceed 30 days.
- **Completion of the MOST form is *not* mandatory.** "A healthcare facility shall not require a person to have executed a MOST form as a condition of being admitted to, or receiving medical treatment from, the healthcare facility" per C.R.S. 15-18.7-108.
- Patient preferences and medical indications shall guide the healthcare professional in completing the MOST form.
- Patients with capacity should participate in the discussion and sign these orders; a healthcare agent, Proxy-by-Statute, or guardian may complete these orders on behalf of an incapacitated patient, *making selections according to patient preferences, if known.*
- "Proxy-by-Statute" is a decision maker selected through a proxy process, per C.R.S. 15-18.5-103(6). Such a decision maker may not decline artificial nutrition or hydration (ANH) for an incapacitated patient without an attending physician and a second physician trained in neurology certifying that "the provision of ANH is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning."
- **Photocopy, fax, and electronic images of signed MOST forms are legal and valid.**

Following the Medical Orders:

- Per C.R.S. 15-18.7-104: **Emergency medical personnel, a healthcare provider, or healthcare facility *shall* comply with an adult's properly executed MOST form that has been executed in this state or another state and is apparent and immediately available.** The fact that the signing physician, advanced practice nurse, or physician assistant does not have admitting privileges in the facility where the adult is receiving care does not remove the duty to comply with these orders. Providers who comply with the orders are immune from civil and criminal prosecution in connection with any outcome of complying with the orders.
- If a healthcare provider considers these orders *medically* inappropriate, she or he should discuss concerns with the patient or surrogate legal decision maker and revise orders only after obtaining the patient or surrogate consent.
- If Section A or B is not completed, full treatment is implied for that section.
- **Comfort care is never optional.** Among other comfort measures, oral fluids and nutrition must be offered if tolerated.
- When "Comfort-focused Treatment" is checked in Section B, hospice or palliative care referral is strongly recommended.
- If a healthcare provider or facility cannot comply with these orders due to policy or ethical/religious objections, the provider or facility must arrange to transfer the patient to another provider or facility and provide appropriate care until transfer.

Reviewing the Medical Orders:

- These medical orders should be reviewed
  - regularly by the person's attending physician or facility staff with the patient and/or patient's legal decision maker;
  - on admission to or discharge from any facility or on transfer between care settings or levels;
  - at any substantial change in the person's health status or treatment preferences; and
  - when legal decision maker or contact information changes.
- If substantive changes are made, please complete a new form and void the replaced one.
- **To void the form, draw a line across Sections A through C and write "VOID" in large letters. Sign and date.**

REVIEW OF THIS COLORADO MOST FORM

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed

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

Colorado Declaration as to Medical or Surgical Treatment

CO

(Living Will)

C.R.S. 15-18-104

I, _____ (name of declarant), being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that:

1. If at any time my attending physician and one other qualified physician certify in writing that:

a. I have an injury, disease, or illness which is not curable or reversible and which, in their judgment, is a terminal condition, and

b. For a period of seven consecutive days or more, I have been unconscious, comatose, or otherwise incompetent so as to be unable to make or communicate responsible decisions concerning my person, then

I direct that, in accordance with Colorado law, life-sustaining procedures shall be withdrawn and withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain. However, I may specifically direct, in accordance with Colorado law, that artificial nourishment be withdrawn or withheld pursuant to the terms of this declaration.

2. In the event that the only procedure I am being provided is artificial nourishment, I direct that one of the following actions be taken:

(initials of declarant) _____ a. Artificial nourishment shall not be continued when it is the only procedure being provided; or

(initials of declarant) _____ b. Artificial nourishment shall be continued for _____ days when it is the only procedure being provided; or

(initials of declarant) _____ c. Artificial nourishment shall be continued when it is the only procedure being provided.

3. I execute this declaration, as my free and voluntary act, this _____ day of _____, 20___.

By _____

Declarant

The foregoing instrument was signed and declared by _____ to be his declaration, in the presence of us, who, in his presence, in the presence of each other, and at his request, have signed our names below as witnesses, and we declare that, at the time of the execution of this instrument, the declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence.

Dated at _____, Colorado, this _____ day of _____, 20_____.

_____

Witness #1's Signature

_____

Name and Address

_____

Witness #2's Signature

_____

Name and Address

STATE OF COLORADO

County of _____

SUBSCRIBED and sworn to before me by _____ , the declarant, and _____ and _____ , witnesses, as the voluntary act and deed of the declarant this _____ day of _____, 20_____.

My commission expires:_____ _____

Notary Public

Advance Directive for Surgical / Medical Treatment (Living Will)

On completion, give copies to your physician, family members, and Healthcare Agent.
If you wish to revoke or replace this document, mark it clearly as "Revoked" or destroy it and all its copies, if possible.
If you do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.

I. DECLARATION

I, _____, am at least eighteen (18) years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

A. Terminal Condition If at any time my physician and one other qualified physician certify in writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

1. Life-Sustaining Procedures (*initial one*)

_____ (*Initials*) I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (*Initials*) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

_____

2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (*Initials*) Artificial nutrition and hydration shall not be continued.

_____ (*Initials*) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____

_____ (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

B. Persistent Vegetative State If at any time my physician and one other qualified physician certify in writing that I am in a Persistent Vegetative State, then:

1. Life-Sustaining Procedures (*initial one*)

_____ (*Initials*) I direct that life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (*Initials*) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

_____

2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (*Initials*) Artificial nutrition and hydration shall not be continued.

_____ (*Initials*) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____

_____ (*Initials*) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

II. OTHER DIRECTIONS

Please indicate below if you have attached to this form any other instructions for your care after you are certified in a terminal condition or Persistent Vegetative State (for instance, to be enrolled in a hospice program, remain at or be transferred to home, discontinue or refuse other treatments such as dialysis, transfusions, antibiotics, diagnostic tests, etc.) *(initial one)*:

_____ (*Initials*) Yes, I have attached other directions.

_____ (*Initials*) No, I do not have any other directions.

III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY (*initial one*)

_____ (*Initials*) My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or after I appointed that Agent.

_____ (*Initials*) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that these persons are not empowered to make any decisions regarding my care, unless I have appointed them as my Healthcare Agents under Medical Durable Power of Attorney.

Name *Relationship*

_____

_____

_____

_____

_____

V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawing life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State. My healthcare providers have my permission to discuss my condition with these persons. I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Agent(s) under Medical Durable Power of Attorney.

Name *Telephone number or email*

_____

_____

_____

_____

_____

VI. ANATOMICAL GIFTS

_____ (*Initials*) I wish to donate my (check one or both)
☐ organs and/or ☐ tissues, if medically possible.

_____ (*Initials*) I do not wish donate my organs or tissues.

VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this day of _____, 20____.

_____
Declarant signature

VIII. DECLARATION OF WITNESSES

This declaration was signed by (*name of Declarant*)

_____

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We did not sign the Declarant's signature. We are not doctors or employees of the attending doctor or healthcare facility in which the Declarant is a patient. We are neither creditors nor heirs of the Declarant and have no claim against any portion of the Declarant's estate at the time this declaration was signed. We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

_____
Signature of Witness

_____
Printed Name

_____
Address

_____
Signature of Witness

_____
Printed Name

_____
Address

Notary (optional)

State of _____
County of _____
SUBSCRIBED and sworn to before me by
_____, the Declarant,
and _____
and _____
witnesses, as the voluntary act and deed of the Declarant this day of _____, 20____.

_____
Notary Public
My commission expires: _____

MEDICAL DURABLE POWER OF ATTORNEY (MDPOA)

- Who here has a designated MDPOA?
- If you don't, who has someone that would make decisions for you if you couldn’t?
- If you don’t, is there anyone that you wouldn’t want making decision for you if you couldn’t?

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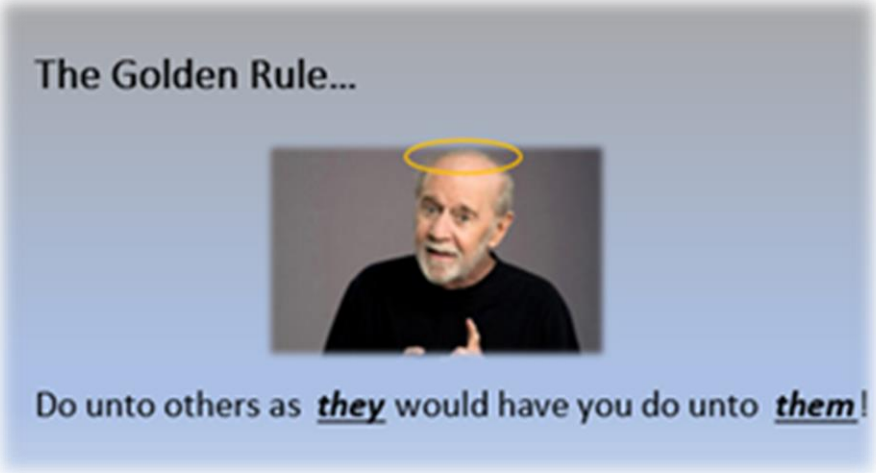
MEDICAL DURABLE POWER OF ATTORNEY (MDPOA) VS. HEALTH CARE PROXY

- MDPOA: You choose who will make decisions
- Proxy: Appointed by healthcare team
- MDPOA: Most likely to accurately represent your wishes



MDPOA IS A DECLARATION

- A person ***identified by you*** to make healthcare decisions for you, in the event that you **lack capacity** to do so for yourself.
- MDPOA does **not require witness or notarization in Colorado**. But it is strongly suggested.
- Must be written and **signed by you.**
- MDPOA is *only authorized to make* ***medical*** *decisions* for you, and only if you are unable to do so for yourself.
- Durable over both time and circumstance.

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PROXY DETERMINATION IS A PROCESS GUIDED BY COLORADO LAW

- The attending physician, or such physician's designee, shall make reasonable efforts to **locate as many interested persons as …practicable**. For the purposes of this section, "**interested persons**" means the patient's spouse, either parent of the patient, any adult child, sibling, or grandchild of the patient, or any close friend of the patient. **C.R.S. § 15-18.5-103**
- It shall be the responsibility of the interested persons … to make reasonable efforts to reach a **consensus as to whom among them** shall make medical treatment decisions on behalf of the patient. **C.R.S. § 15-18.5-103**
- **Proxy determination is a process** – It is described by hospital policy and informed by state statute. The important thing is that it is a gathering of all interested parties to ***self select that person who will make decisions for the patient*** in the patient's best interest.

Colorado law does not recognize presumptive proxy hierarchy.

HEALTH CARE PROXY

- They are appointed-you don't get a say.
- They are only valid during the hospital admission during which they are appointed.
- They are unable to speak for you outside the hospital.
- A new proxy process needs to be performed at each hospital admission, regardless of which hospital you're admitted to.

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ABA TOOL: HOW TO SELECT YOUR HEALTH CARE AGENT OR PROXY

Compare up to 3 people with this tool. The persons best suited to be your Health Care Agents or Proxies rate well on these qualifications...

	Name #1:	*Name #2:*	*Name #3:*
1.			Meets the legal criteria in your state for acting as agent or proxy or representative? (This is a must! See next page.)
2.			Would be willing to speak on your behalf.
3.			Would be able to act on your wishes and separate his/her own feelings from yours.
4.			Lives close by or could travel to be at your side if needed.
5.			Knows you well and understands what's important to you.
6.			Is someone you trust with your life.
7.			Will talk with you now about sensitive issues and will listen to your wishes.
8.			Will likely be available long into the future.
9.			Would be able to handle conflicting opinions between family members, friends, and medical personnel.
10.			Can be a strong advocate in the face of an unresponsive doctor or institution.

CASE OVERVIEW — FAMILY CONFLICT AFTER SEVERE STROKE

- 76-year-old mother of three adult children.
- She suffers a giant stroke resulting in profound neurological impairment.
- In the ICU, intubated, unresponsive, and dependent on life-sustaining care (mechanical ventilation, nutrition support).
- Minimal chance of meaningful recovery according to the medical team.
- No advance directive, living will, or MDPOA.

CASE OVERVIEW — FAMILY CONFLICT AFTER SEVERE STROKE

- She valued independence and dignity.
- She would never have wanted any of this.
- Plans to withdraw life-sustaining interventions

  But then…

- The third child arrives from out of town just as these plans are being finalized.

CASE OVERVIEW — FAMILY CONFLICT AFTER SEVERE STROKE

- Advance care planning can prevent confusion and conflict during medical crises.
- The whole family benefits from discussing goals of care before emergencies occur.
- When end-of-life decisions must be made without clear documentation of patient, wishes the patient, the family, and the healthcare team stand to suffer.

the conversation project
in boulder county
a program of TRU | CommunityCare

NAME _____ DATE _____

The Conversation Project is dedicated to helping peop
wishes for end-of-life care. We developed the Convers
help you get started with what we know can be challer
encourage you to use this tool to identify your values.
to a conversation. You may wish to visit: theconversat
download the full version of the Starter Kit that comes
information about how and why the conversation is so

When should you have the conversation?

Even if you're in good health, it's still important to make sure your loved ones, and you
since anyone's health status can change suddenly. It's particularly important to have t
a chronic or serious illness. Every conversation will help your loved ones and your car

? **As you think about how you want to live at the end of your life, what's most
Now finish this sentence: What matters to me at the end of life is...**
(For example, being able to recognize my children; being in the hospital with excellent nursing ca

Where I Stand Scales

Select the number that best represents your wishes. (You can write on the dotted line
or add notes about your answer.)

As a patient, I'd like to know...

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Only the basics about my condition and my treatment — All the details about my condition and my treatment

If I had a termina

○ 1 ○ 2

Not know how quickly it is progressing

As doctors treat me, I would like...

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

My doctors to do what they think is best — To have a say in every decision

How long do you

○ 1 ○ 2

Indefinitely, no matt
how uncomfortable
treatments are

Institute for Healthcare Improvement www.ihi.org







Your Conversation Starter Guide

How to talk about what matters to you and have a say in your health care.

Institute for Healthcare Improvement

the conversation project

s about treatment?

○ 3 ○ 4 ○ 5

I'm worried that I'll get overly aggressive care

How involved do you want your loved ones to be?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I want my loved ones to do exactly what I've said, even if it makes them a little uncomfortable — I want my loved ones to do what brings them peace, even if it goes against what I've said

ces about where you want to be?

○ 3 ○ 4 ○ 5

I want to spend my last days at home

When it comes to sharing information...

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I don't want my loved ones to know everything about my health — I am comfortable with those close to me knowing everything about my health

**nt to make decisions on your behalf if you're not able to? (This person is called
Power of Attorney (MDPOA), or Agent, in the State of Colorado. More information is
://coloradocareplanning.org)**

articular concerns (questions, fears) about your health? About the last phase of your life?

**re the three most important things that you want your friends, family, and/or doctors
ut your wishes and preferences for end-of-life care?**

or
ent

COLORADO CARE PLANNING
ColoradoCarePlanning.org

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EATED BY THE CONVERSATION PROJECT AND THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

rovement www.ihi.org

www.theconversationprojectinboulder.org

PREPARE FOR YOUR CARE

Boulder Community Health

Step 1

Choose a Medical Decision Maker

Step 2

Decide What Matters Most in Life

Step 3

Choose Flexibility for Your Decision Makers

Step 4

Tell Others About Your Wishes

Step 5

Ask Your Medical Care Team Questions

Easy-To-Read Advance Directives

Free and legal in all US states

(prepareforyourcare.org)

Boulder Community Health

HELPING OTHERS - DIFFICULT CONVERSATIONS

Important Ways Planning Is Different for Each Person

How To Bring Up the Topic of Medical Planning

How To Ask Other People About Their Medical Wishes

How To Help Other People Write Down Medical Wishes

CASE OVERVIEW — SEVERE TRAUMATIC BRAIN INJURY IN A YOUNG ADULT

- 23-year-old male involved in a high-speed scooter crash.
- Sustained a severe traumatic brain injury with no chance of meaningful neurological recovery.
- In the ICU, dependent on mechanical ventilation and life-sustaining treatment.
- Medical consensus indicates irreversible brain damage and poor outcome.
- No advance directive, MDPOA or documentation of prior healthcare preferences.

CASE OVERVIEW — SEVERE TRAUMATIC BRAIN INJURY IN A YOUNG ADULT

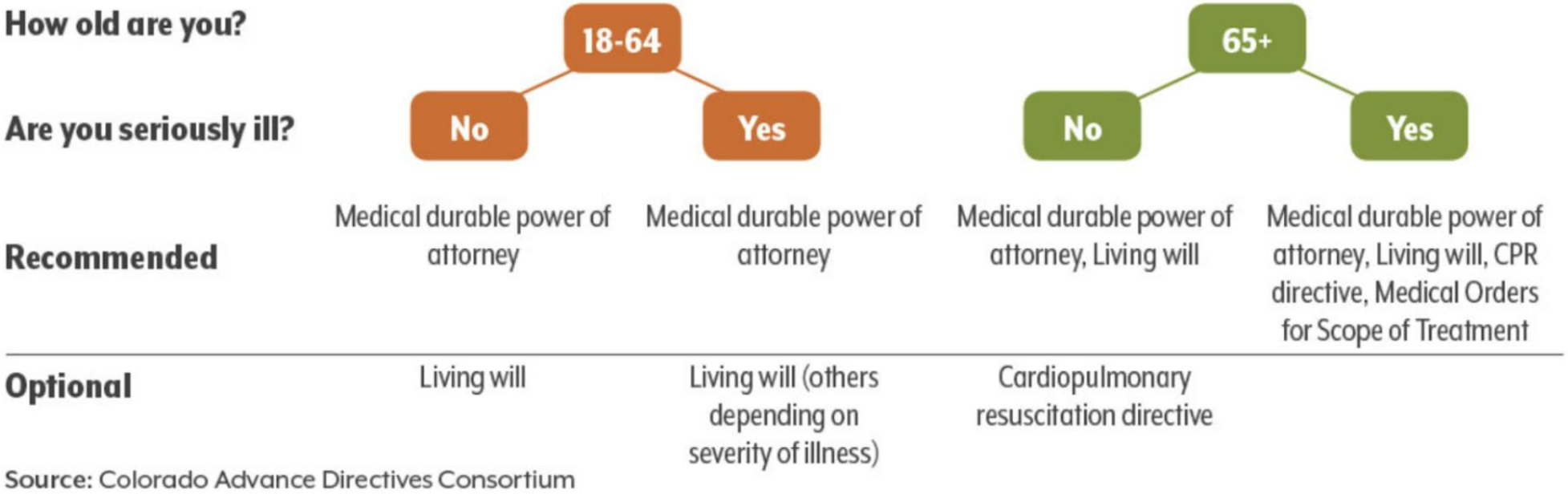
- The patient has lived with his best friends for the past three years.
- Roommates report that he doesn't have much contact with his parents.
- They share that he often said he wouldn't want to live in a dependent or vegetative state.
- The parents arrive at the hospital before any decisions are made.
- They insist that all life-sustaining treatments be continued indefinitely.
- The best friends and the parents are in direct conflict about how to proceed.

Who has decision-making authority?
(HINT: very difficult proxy process)

Boulder Community Health

What advance directive is right for me?

Figure 1: How to Determine Which Advance Directives Are Right For You



Source: Colorado Advance Directives Consortium

THANK YOU !

Boulder Community Health

RESOURCES

- https://cdphe.colorado.gov/palliative-care/advance-care-planning-for-patients-and-families
- https://www.patientdecisionaid.org (for healthcare providers)
- https://www.cchacares.com/AdvanceCarePlan
- https://www.theconversationprojectinboulder.org
- https://prepareforyourcare.org/en/prepare-for-your-care/advance-directive/advance-directive-welcome

Boulder Community Health

MEDICAL AID IN DYING - MAID

- Colorado End Of Life Options Act 2016 – Revised in 2024
- Passed with ~ 2/3 Colorado voters in favor
- Must be over 18
- Terminal illness with a prognosis of six months or less to live if the disease takes its natural course
- Mental capacity to make this medical decision
- Voluntarily express this request for a prescription for medical aid-in-dying medication
- 2 providers
- 7 day waiting period

Boulder Community Health Foundation

Over 40 Years of Community Impact

Enhancing the quality and availability of health care in our community

COMMUNITY

We believe everyone should have a fair and just opportunity to reach their full health potential, both physically and mentally.

PATIENTS

We believe providing the community with the highest value in health care requires an innovative, patient-centered environment.

WORKFORCE

We believe it's imperative to invest in the professional growth and physical and mental health of BCH's greatest asset—the staff and physicians providing care to the community.

Learn more at **bch.org/foundation**

ADVANCE CARE PLANNING:
Empowering you to make informed choices

Barry Platnick, MD, FACS, MSPC
Medical Director for Palliative Care, Boulder Community Health
Trauma and Acute Care Surgeon BCH/Denver Health
Assistant Professor of Surgery CUSOM
Barry.Platnick@bch.org

Boulder Community Health