Welcome to Utah's 6th Annual

March 31, 2022

12:00 Noon – 1:30 PM

Summit Agenda:

Time	Topic	Presenter
12:00 – 12:05	Welcome	Rob Ence & Adrienne Butterwick
12:05 – 12:35 12:35 – 12:45	Keynote Presentation Q&A	Cami Collett, MD, MPH
12:45 – 1:00	Personal Story	Sherry Myers
1:00 – 1:40	Interdisciplinary Community Conversation	Panel

Objectives:

- Understand best practices for advance care planning across the treatment continuum
- Describe key steps for emergency preparedness as it relates to all stages of life
- Apply strategies for inclusive approaches in advance care planning

Comagine Health

Using Zoom

Turn on your camera if you are able

Mute yourself when not speaking to limit background noise

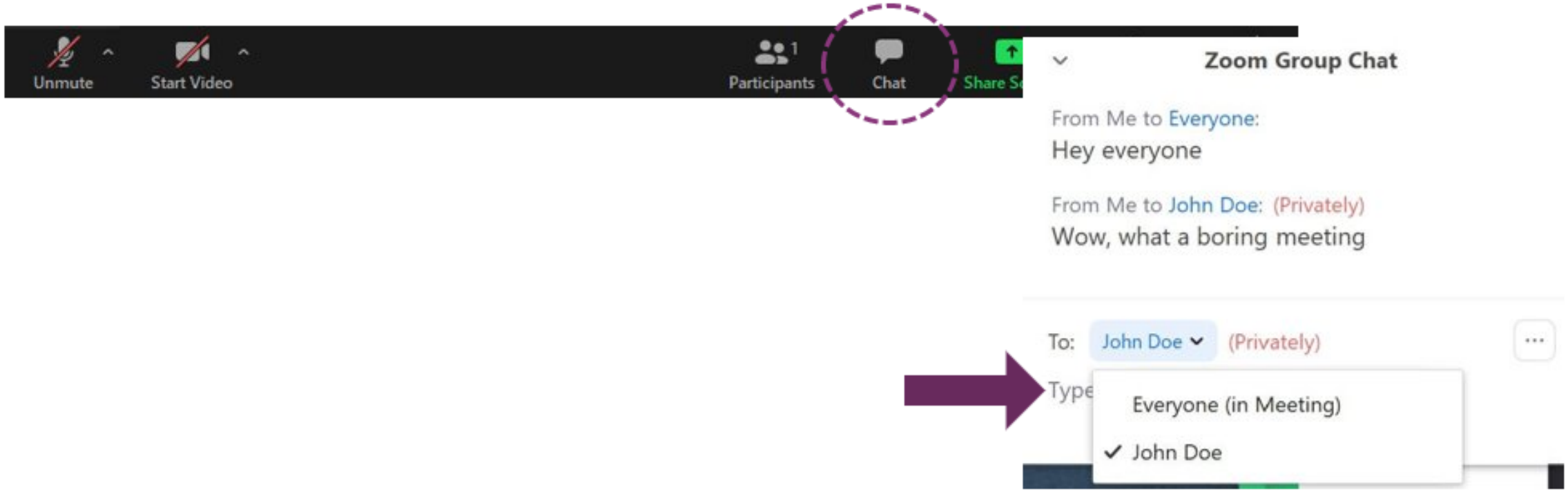
- *If calling in via phone, dial *6 to mute/unmute yourself*

Comagine Health

Using Zoom

Feel free to type questions, ideas, and feedback into the chat

- *You can send messages to everyone or to specific people*



Comagine Health

Logistics and Details

- A recording of the event will be sent out when available
- Power point presentations and other resources mentioned will be shared via email after the summit
- This event has been approved for 1.0 Nursing CEU and 1.5 Social Work/Ethics CEU – **please complete the survey you receive via email to claim your credit**
- Feel free to put questions in chat as we go and/or unmute during Q&A timing

Comagine Health

Thank You to our planning committee

Advance Care Planning Summit

Comagine Health

UtahAging.org
Utah Commission on Aging

Holy Cross Ministries

Salt Lake Interfaith Roundtable

Homecare & Hospice Association of Utah

U HEALTH
UNIVERSITY OF UTAH

U COLLEGE OF NURSING
UNIVERSITY OF UTAH

Intermountain Healthcare

UGEC
UTAH GERIATRIC EDUCATION CONSORTIUM

St. Mark's Family Medicine
a division of Utah HealthCare Institute

Advance Care Planning Summit

Thank You to Our Legacy ACP Advisors!

- Bright Star Care
- Comagine Health
- Holy Cross Ministries
- Homecare and Hospice Association of Utah
- Huntsman Cancer Institute
- Intermountain Healthcare
- Mission Health Services
- Muscular Dystrophy Association
- Regence Blue Cross Blue Shield
- Salt Lake Interfaith Roundtable
- Summit Vista
- St. Mark's Hospital
- The University of Utah School of Medicine
- Utah Department of Health
- University of Utah College of Nursing
- University of Utah Health Utah Geriatric Education Consortium
- Utah Commission on Aging
- Utah Health Information Network
- Utah Hospital Association

Comagine Health

Advance Care Planning Summit

Keynote Presentation

Camille Collett, MD, MPH

Conversations about Being Mortal

Camille Collett, MD, MPH

March 31, 2021

Each of us have a story about our own experience with death.

Cultural Challenges

Discussing the death of someone to their face is taboo. Negative words and thoughts about health become self-fulfilling

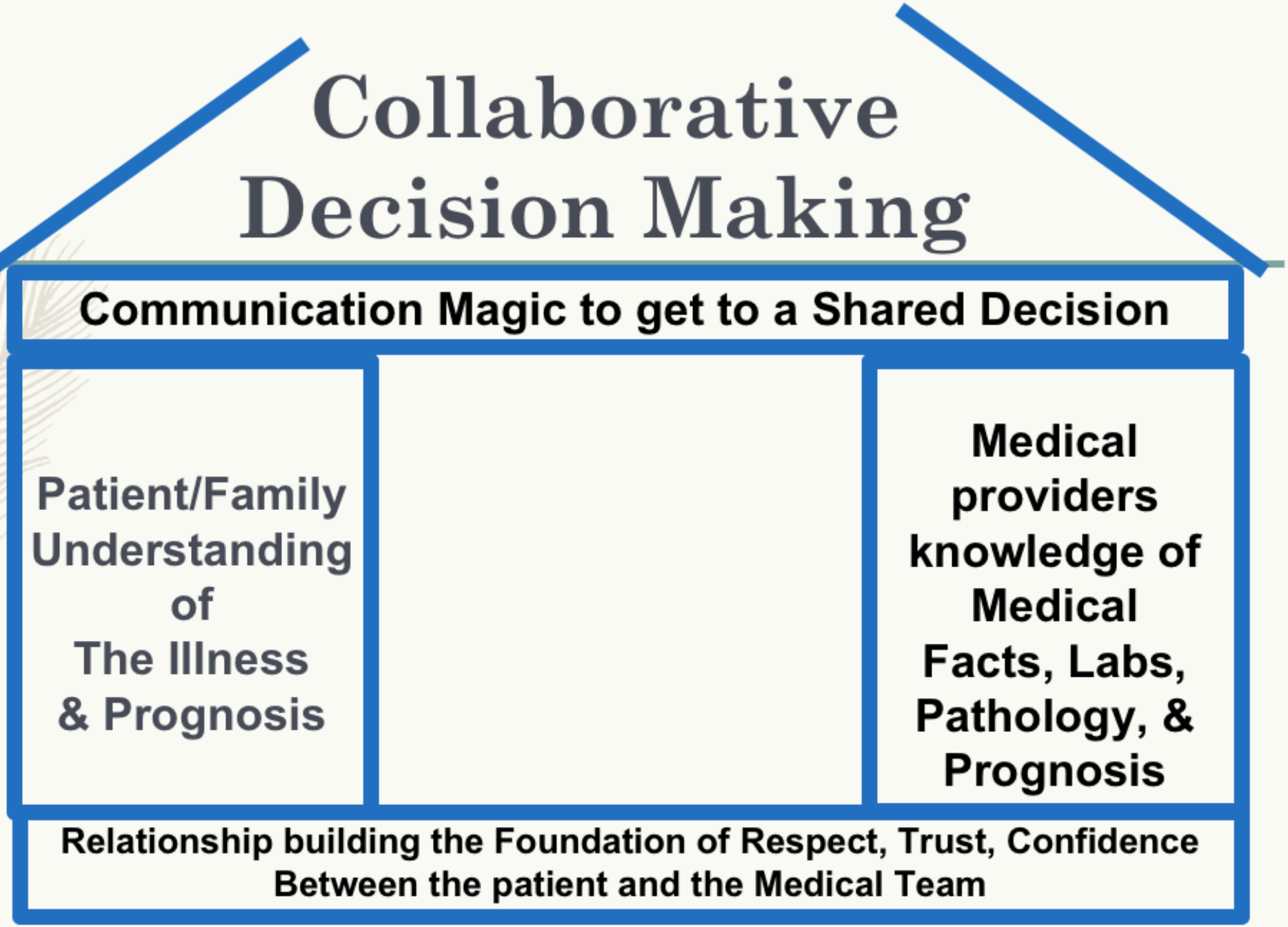
Reluctance to discuss the possibility of death based on the belief that miracles can happen, and acknowledging mortality may be giving up

May lose trust in the medical providers if DNR code is offered as an option since death is in the hands of God

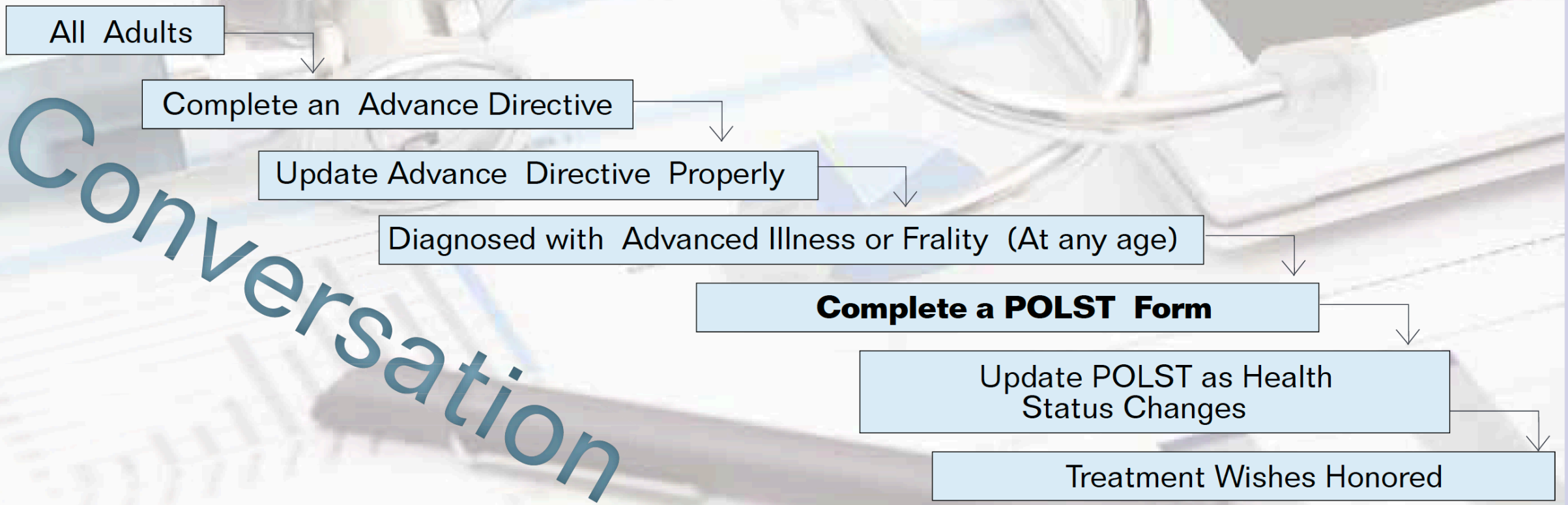
Cultural Challenges

- Talking about Death is Taboo
- Language barriers and use of interpreters
- Traditional head of household may not be the best spokesperson for the patient
- Traditions for the body after death can vary

Collaborative Decision Making



How An Advance Directive and POLST Form Work Together



Differences between POLST and advance directives

CHARACTERISTICS	POLST	ADVANCE DIRECTIVES
Population	For the seriously ill	All adults
Time frame	Current care	Future care
Who completes the form	Health care professionals	Patients
Resulting form	Medical orders (POLST)	Advance directive
Health care agent or surrogate role	Can engage in discussion if patient lacks capacity	Cannot complete
Portability	Provider responsibility	Patient/family responsibility
Periodic review	Provider responsibility	Patient/family responsibility

POLST = Physician Orders for Life-Sustaining Treatment

The D's For reviewing Advance Directives

Decade

Death

Divorce

Diagnosis (New Illness or New Cancer)

Decline in Health

***If you move to or live part time in a Different state for the winter months.**

Advance Directives

ADVANCE CARE DIRECTIVES ENGLISH >

ADVANCE DIRECTIVES BILINGUAL >

ADVANCE CARE GUIDE >

Edit Sign

POLST

POLST DOCUMENT >

POLST SPANISH >

E-POLST REGISTRY >

Edit Sign

POLST Conversation Guide

Important guidance on conducting end of life conversations including the completion of the POLST form (Provider Order of Life Sustaining Treatment).

POLST CONVERSATION GUIDE >

Resources

Media

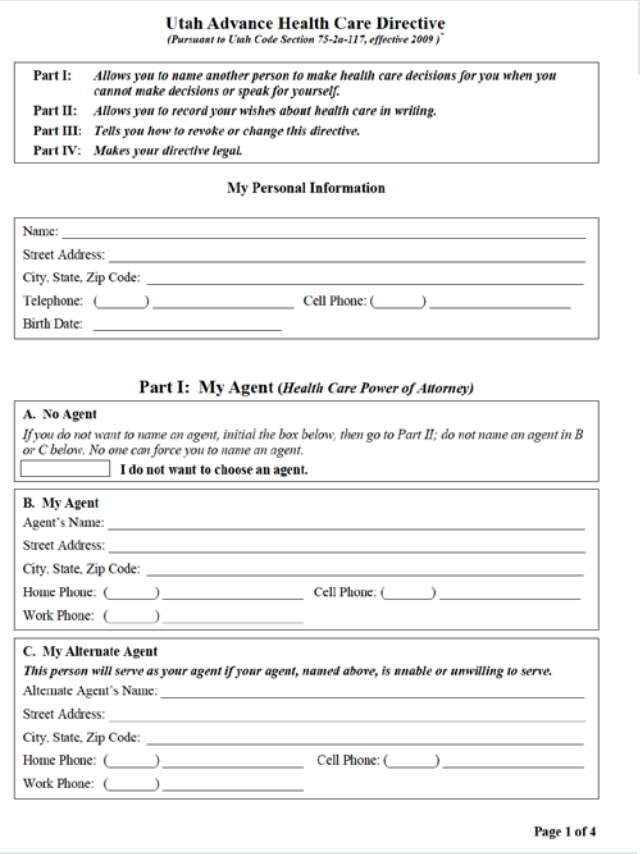
Advance Care Planning Overview

Advance Directives

POLST Agreements

Utah POLST with Dr. Camille Collett, MD, MPH

Utah Advance Directive



Utah Advance Health Care Directive

(Pursuant to Utah Code Section 75-2a-117, effective 2009)

Part I: *Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.*
Part II: *Allows you to record your wishes about health care in writing.*
Part III: *Tells you how to revoke or change this directive.*
Part IV: *Makes your directive legal.*

My Personal Information

Name: _____
Street Address: _____
City, State, Zip Code: _____
Telephone: (_____) _____ Cell Phone: (_____) _____
Birth Date: _____

Part I: My Agent (*Health Care Power of Attorney*)

A. No Agent

If you do not want to name an agent, initial the box below, then go to Part II; do not name an agent in B or C below. No one can force you to name an agent.

[ ] **I do not want to choose an agent.**

B. My Agent

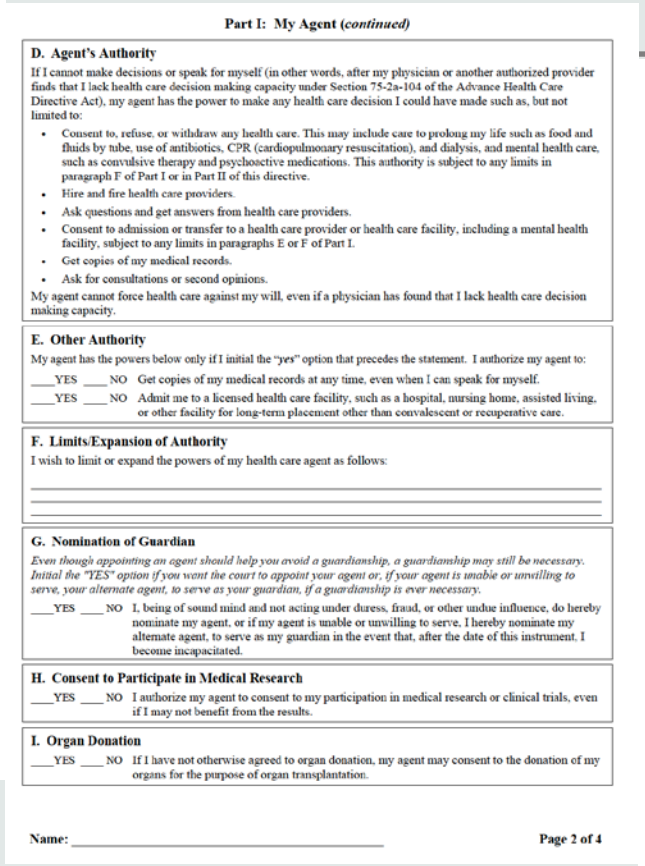
Agent's Name: _____
Street Address: _____
City, State, Zip Code: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
Work Phone: (_____) _____

C. My Alternate Agent

This person will serve as your agent if your agent, named above, is unable or unwilling to serve.

Alternate Agent's Name: _____
Street Address: _____
City, State, Zip Code: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
Work Phone: (_____) _____

Page 1 of 4



Part I: My Agent (*continued*)

D. Agent's Authority

If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider finds that I lack health care decision making capacity under Section 75-2a-104 of the Advance Health Care Directive Act), my agent has the power to make any health care decision I could have made such as, but not limited to:

- Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of Part I or in Part II of this directive.
- Hire and fire health care providers.
- Ask questions and get answers from health care providers.
- Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E or F of Part I.
- Get copies of my medical records.
- Ask for consultations or second opinions.

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity.

E. Other Authority

My agent has the powers below only if I initial the "*yes*" option that precedes the statement. I authorize my agent to:

___YES ___NO Get copies of my medical records at any time, even when I can speak for myself.
___YES ___NO Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

F. Limits/Expansion of Authority

I wish to limit or expand the powers of my health care agent as follows:

_____
_____
_____

G. Nomination of Guardian

Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary. Initial the "YES" option if you want the court to appoint your agent or, if your agent is unable or unwilling to serve, your alternate agent, to serve as your guardian, if a guardianship is ever necessary.

___YES ___NO I, being of sound mind and not acting under duress, fraud, or other undue influence, do hereby nominate my agent, or if my agent is unable or unwilling to serve, I hereby nominate my alternate agent, to serve as my guardian in the event that, after the date of this instrument, I become incapacitated.

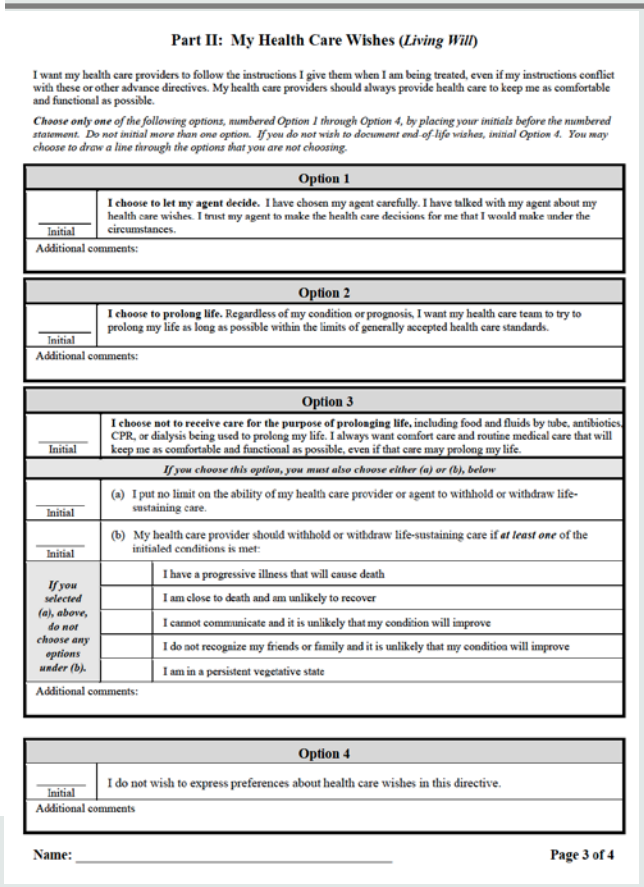
H. Consent to Participate in Medical Research

___YES ___NO I authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

I. Organ Donation

___YES ___NO If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.

Name: _____ **Page 2 of 4**



Part II: My Health Care Wishes (*Living Will*)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

***Choose only one** of the following options, numbered Option 1 through Option 4, by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may choose to draw a line through the options that you are not choosing.*

Option 1

_____ Initial — **I choose to let my agent decide.** I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances.

Additional comments:

Option 2

_____ Initial — **I choose to prolong life.** Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards.

Additional comments:

Option 3

_____ Initial — **I choose not to receive care for the purpose of prolonging life,** including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life.

If you choose this option, you must also choose either (a) or (b), below

_____ Initial — (a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care.

_____ Initial — (b) My health care provider should withhold or withdraw life-sustaining care if ***at least one*** of the initialed conditions is met:

If you selected (a), above, do not choose any options under (b).		I have a progressive illness that will cause death
		I am close to death and am unlikely to recover
		I cannot communicate and it is unlikely that my condition will improve
		I do not recognize my friends or family and it is unlikely that my condition will improve
		I am in a persistent vegetative state

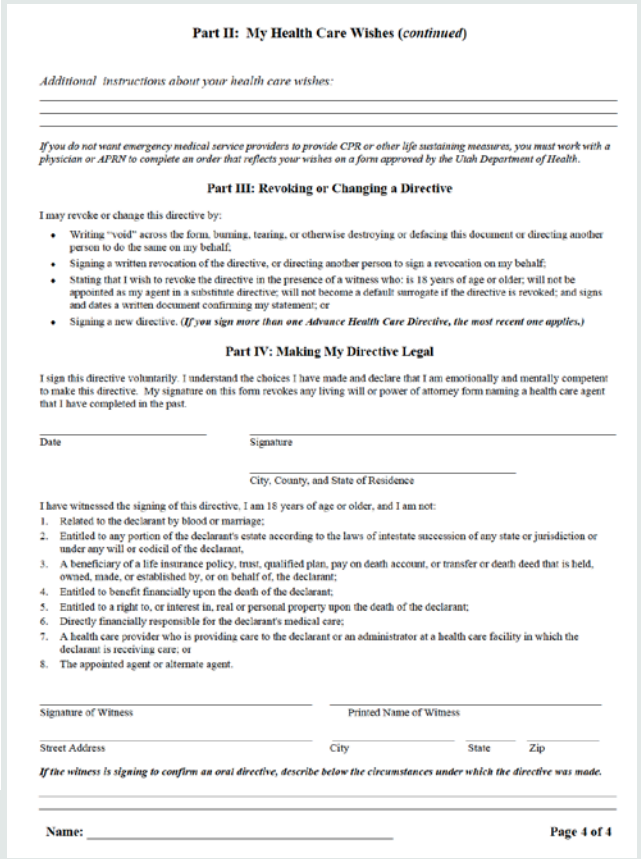
Additional comments:

Option 4

_____ Initial — I do not wish to express preferences about health care wishes in this directive.

Additional comments

Name: _____ **Page 3 of 4**



Part II: My Health Care Wishes (*continued*)

Additional instructions about your health care wishes:

_____
_____
_____

If you do not want emergency medical service providers to provide CPR or other life sustaining measures, you must work with a physician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health.

Part III: Revoking or Changing a Directive

I may revoke or change this directive by:

- Writing "void" across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
- Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;
- Stating that I wish to revoke the directive in the presence of a witness who: is 18 years of age or older; will not be appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement; or
- Signing a new directive. (***If you sign more than one Advance Health Care Directive, the most recent one applies.***)

Part IV: Making My Directive Legal

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent that I have completed in the past.

_____ _____
Date Signature

_____
City, County, and State of Residence

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

1. Related to the declarant by blood or marriage;
2. Entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant,
3. A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer or death deed that is held, owned, made, or established by, or on behalf of, the declarant;
4. Entitled to benefit financially upon the death of the declarant;
5. Entitled to a right to, or interest in, real or personal property upon the death of the declarant;
6. Directly financially responsible for the declarant's medical care;
7. A health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
8. The appointed agent or alternate agent.

_____ _____
Signature of Witness Printed Name of Witness

_____ _____ _____ _____
Street Address City State Zip

If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.

_____
_____

Name: _____ **Page 4 of 4**

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If you selected (a), above, do not choose any options under (b).	_____	I have a progressive illness that will cause death
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	_____	I cannot communicate and it is unlikely that my condition will improve
	_____	I do not recognize my friends or family and it is unlikely that my condition will improve
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Additional comments:		

Option 4	
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Additional comments	

Name: _____

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Additional instructions about your health care wishes:

_____

_____

_____

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- Stating that I wish to revoke the directive in the presence of a witness who: is 18 years of age or older; will not be appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement; or
- Signing a new directive. ***(If you sign more than one Advance Health Care Directive, the most recent one applies.)***

Part IV: Making My Directive Legal

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent that I have completed in the past.

_____ Date

_____ Signature

_____ City, County, and State of Residence

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

1. Related to the declarant by blood or marriage;
2. Entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant,
3. A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer or death deed that is held, owned, made, or established by, or on behalf of, the declarant;
4. Entitled to benefit financially upon the death of the declarant;
5. Entitled to a right to, or interest in, real or personal property upon the death of the declarant;
6. Directly financially responsible for the declarant's medical care;
7. A health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
8. The appointed agent or alternate agent.

_____ Signature of Witness

_____ Printed Name of Witness

_____ Street Address

_____ City

_____ State

_____ Zip

If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.

_____

_____

Name: _____

What is CPR

Cardiopulmonary resuscitation

On TV, **77%** of people survive CPR but this is not what happens in real life.

Survival Rate of In-Hospital Cardiac Arrests if over 65

Among "elderly patients who undergo resuscitation after in-hospital cardiac arrest", at one year:

- 49 died during resuscitation
- 34 died before hospital discharge
- 7 died after hospital discharge
- 10 are alive

GeriPal Podcast, (2013) *Outcomes of In-Hospital CPR: Not as Rosy as Some May Say*.

Provider Order for Life-Sustaining Treatment (POLST)

Utah Life with Dignity Order

Bureau of Licensing and Certification, Utah Department of Health
State of Utah Rule R432-31 v3.1 February 2019 (http://health.utah.gov/hflcra/forms.php)

Patient's Last Name		First Name/Middle Initial		Effective Date of this Order	
Date of Birth		Last 4 of SS#		Address (street/city/state/zip)	
Medical Provider's Name (MD/DO/PA/APRN)				Medical Provider's Phone	
Brief description of patient's medical condition					
Patient's stated goals for medical care					

A. CARDIOPULMONARY RESUSCITATION (CPR) Treatment options when the patient **does not have a pulse and is not breathing** (CHECK ONE)

- ☐ Attempt to resuscitate (selecting attempt to resuscitate requires selecting full treatment in Section B)
- ☐ Do not attempt or continue any resuscitation (DNR) (Allow Natural Death)
- ☐ I do not wish to express a preference (selecting this may lead to attempt to resuscitate)

B. MEDICAL INTERVENTIONS Treatment options when the patient **has a pulse and is breathing** (CHECK ONE)

- ☐ **FULL TREATMENT:** *Prolonging life by all medically effective means.* Medical care may include endotracheal intubation, mechanical ventilation, defibrillation/ cardioversion, vasopressors, and any other life-sustaining care that is required. Also includes medical care described below.
- ☐ **LIMITED ADDITIONAL INTERVENTIONS:** *Treating medical conditions while avoiding burdensome measures.* Medical care may include treatment of airway obstruction, bag/valve/mask ventilation, monitoring of cardiac rhythm, IV fluids, IV antibiotics and other medications as indicated. Also includes medical care described below. No endotracheal intubation or mechanical ventilation. Generally avoid the Intensive Care Unit.
- ☐ **COMFORT MEASURES:** *MAXIMIZING comfort and dignity.* Medical care may include oral and body hygiene, reasonable efforts to offer food and fluids orally, medication, oxygen, positioning, warmth and other measures to relieve pain and suffering. Transfer to the hospital only if comfort measures can no longer be managed at the current setting.
- ☐ **NO PREFERENCE:** I do not wish to express a preference (selecting this may lead to full treatment).

Other Instructions or clarification; Describe goals and/or time period if a trial intervention is desired:

UTAH POLST UTAH POLST UTAH

C. ARTIFICIAL NUTRITION

- [ ] Long term artificial nutrition with feeding tube
- [ ] Trial period of artificial nutrition with feeding tube
- [ ] No artificial nutrition
- [ ] I do not wish to express a preference

Describe goals and/or time period if a trial is desired:

D. ADVANCE DIRECTIVE AND PATIENT PREFERENCES

- [ ] Advance Directive available, reviewed and confirmed without conflicts
- [ ] No Advance Directive available

Health care agent named in Advance Directive | Phone Number

- [ ] I, the patient, want this order to serve as a general guide. I understand in some situations, the person making decisions for me may decide something different if they think it is consistent with my preferences.
- [ ] I, the patient, want this order to be followed strictly.

Discussed with:

REQUIRED SIGNATURES

Print Name	Relationship: (write self if patient)	Signature

Signature of Medical Provider (MD/DO/PA/APRN) Two signatures required for minors	Print Name	License Number	Date

Signature of licensed professional preparing form	Print Name	Title	Date

POLST UTAH POLST UTAH POLST

New Legislation for Signature Requirement for Utah POLST

POLST Order was updated in 2021 with the Utah State Legislature approving a verbal confirmation satisfies the requirement for a signature from an individual

https://le.utah.gov/~2021/bills/static/SB0083.html

ACP Resources

UTAHAGING.ORG

- POLST CONVERSATION GUIDE

LEAVINGWELL.ORG

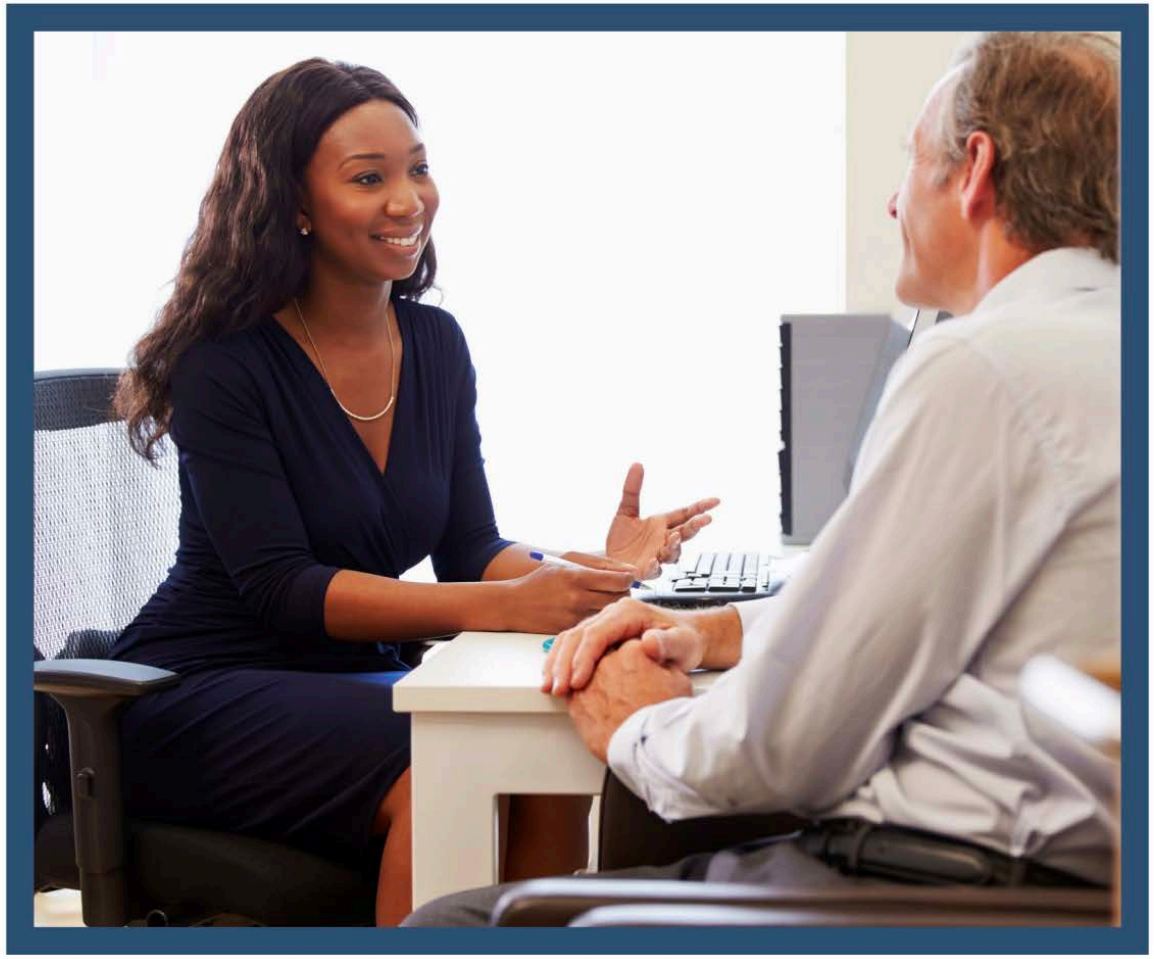
POLST.ORG

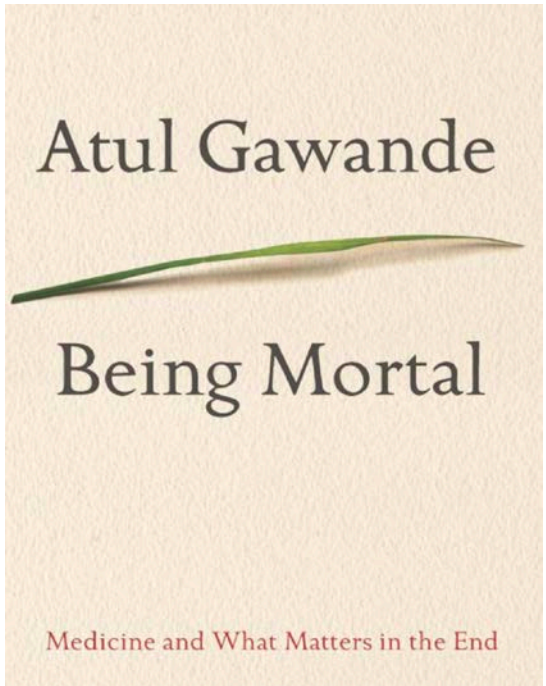
THECONVERSATIONPROJECT.ORG

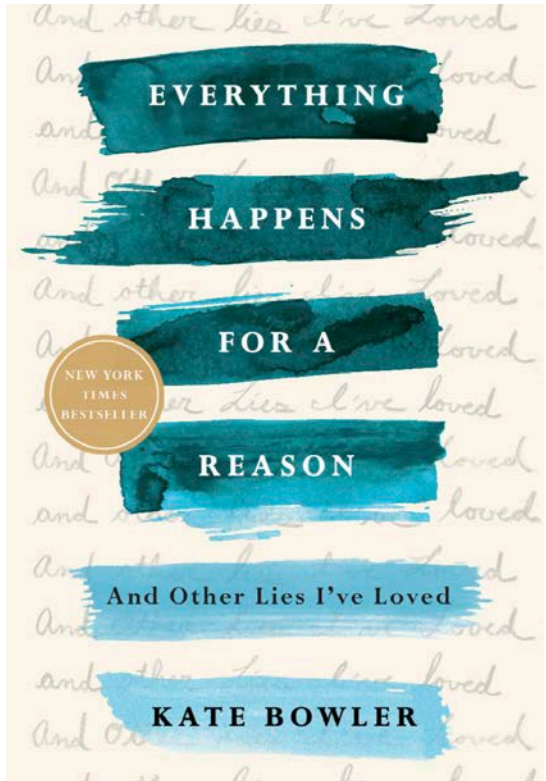
PREPAREFORYOURCARE.ORG

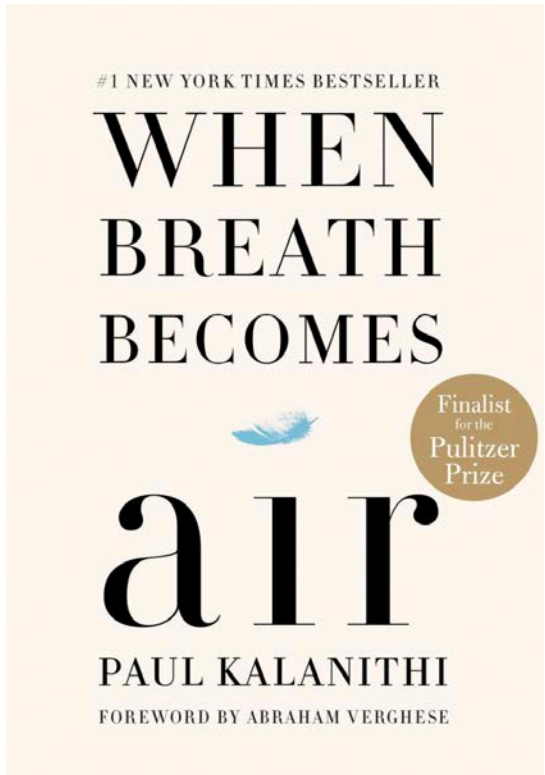
FIVEWISHES.ORG

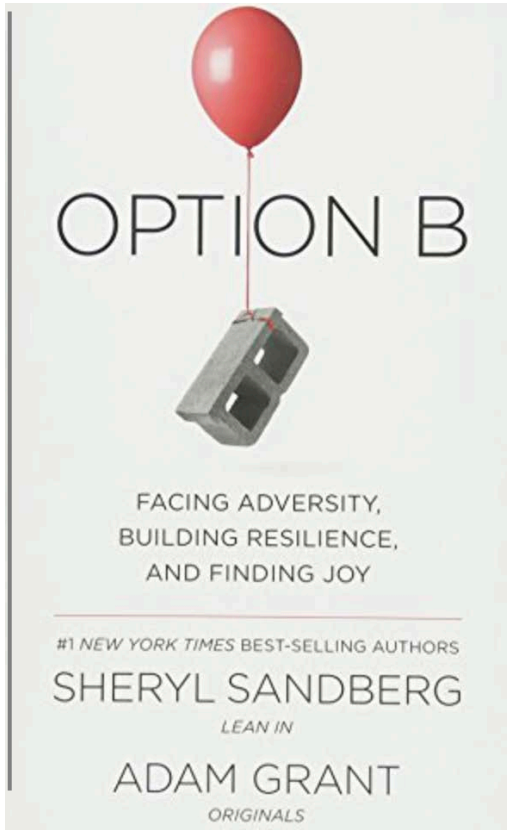
POLST
Conversation Guide



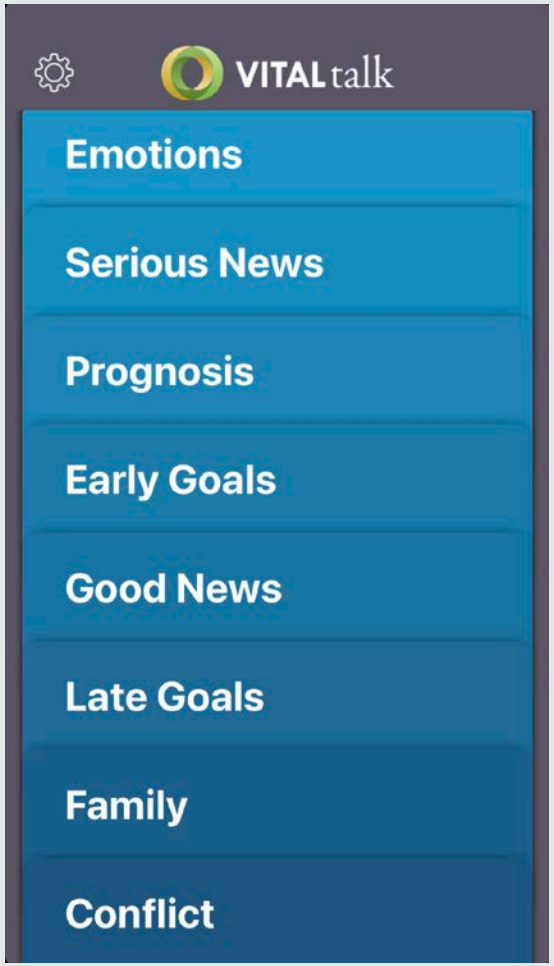

Atul Gawande
Being Mortal
Medicine and What Matters in the End

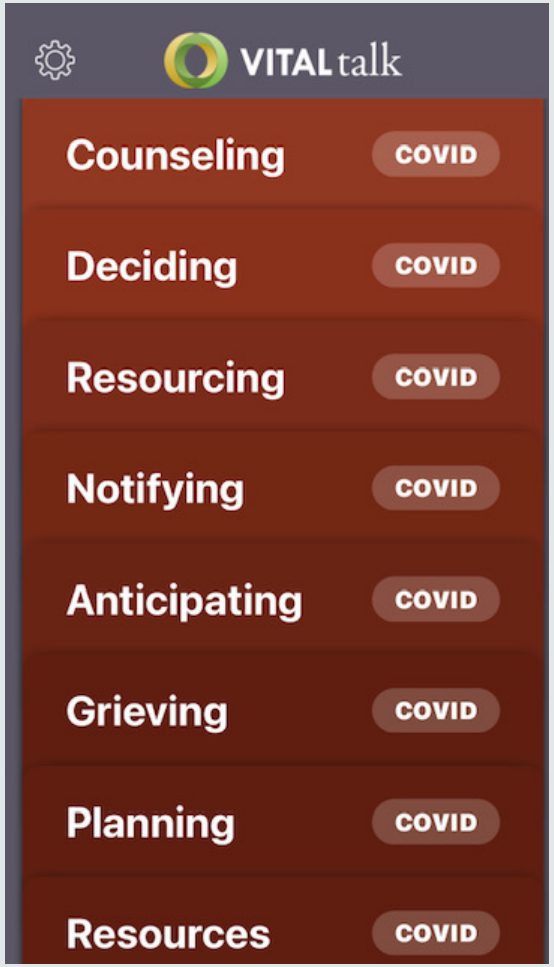

EVERYTHING
HAPPENS
FOR A
REASON
NEW YORK TIMES BESTSELLER
And Other Lies I've Loved
KATE BOWLER


#1 NEW YORK TIMES BESTSELLER
WHEN BREATH BECOMES
air
Finalist for the Pulitzer Prize
PAUL KALANITHI
FOREWORD BY ABRAHAM VERGHESE


OPTION B
FACING ADVERSITY, BUILDING RESILIENCE, AND FINDING JOY
#1 NEW YORK TIMES BEST-SELLING AUTHORS
SHERYL SANDBERG
LEAN IN
ADAM GRANT
ORIGINALS

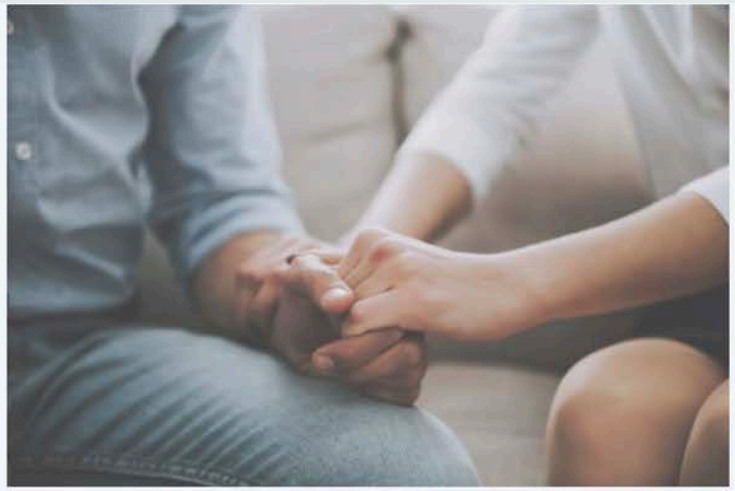
VITAL talk





VitalTalk.org

There is an app for that
VitalTips (Palliative Care)



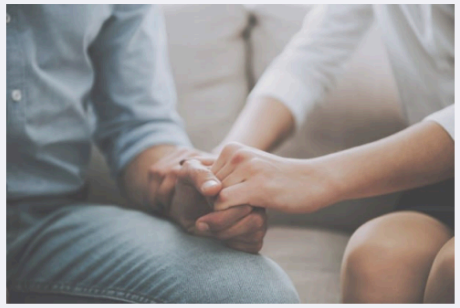
UCoPE

Utah Certificate *of* Palliative Education

2022 CONFERENCES

SPRING: APRIL 19-22 FALL: OCTOBER 18-21

Utah Certificate of Palliative Care Education (UCoPE) at the University of Utah. UCoPE is a four-day intensive course designed for health care providers who want to improve their generalist palliative care skills.



UCoPE

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SPRING: APRIL 19-22 FALL: OCTOBER 18-21

UCoPE is a four-day intensive course designed for health care providers who want to improve their generalist palliative care skills.

Over four days participants will learn a combination of communication and symptom management skills training in an intimate setting with a faculty-to-student ratio of 2 - 3:1.

Facilitators from pediatrics, internal medicine, oncology, psychiatry, and geriatrics will guide the courses. Attendees will be exposed to best palliative care practices in a variety of clinical settings including: inpatient, ICU, emergency department, outpatient clinics, and hospice care.

Topics include:

- ◊ Communication Skills
- ◊ Ethics in Palliative Care
- ◊ Grief
- ◊ Dealing with Conflicts
- ◊ Cultural Curiosity
- ◊ Professional Self Care

Spring 2022 UCoPE
Tuesday, April 19—Friday, April 22
Registration information:

Physician registration:	$500.00
Non-physician registration	$300.00

This is a virtual Zoom videoconference

Registration now open!
Limited spaces available

To register, email UCOPE@hsc.utah.edu
or go to: https://umarket.utah.edu/um2/UCOPE/

Attendees may claim up to
26.25 CME credits

UCoPE
Utah Certificate *of* Palliative Education

HEALTH
UNIVERSITY OF UTAH

UNIVERSITY OF UTAH
HUNTSMAN
CANCER INSTITUTE

QUESTIONS? Email UCOPE@hsc.utah.edu visit our website or call Melody Baugh at 801-662-3645

April 16th is

Advance Care Planning Summit

Personal Story

Sherry Myers
Community Liaison
Danville Support Services

Interdisciplinary Community Panel Discussion

Advance Care Planning Summit

Maria Cruz-Gray, Hispanic Ministry Director, Catholic Diocese of Salt Lake City

Jani Iwamoto, J.D., Senator for Utah Senate District 4

Andrew Layne, LCSW, Hospice Provider, Intermountain Healthcare

Sherry Myers, Community Liaison, Danville Support Services

Thank you for joining us!

Comagine Health

UtahAging.org
Utah Commission on Aging

Holy Cross MINISTRIES

Salt Lake Interfaith Roundtable

Homecare & Hospice Association of Utah

HEALTH
UNIVERSITY OF UTAH

COLLEGE OF NURSING
UNIVERSITY OF UTAH

Intermountain Healthcare

UTAH GERIATRIC EDUCATION CONSORTIUM
UGEC

St. Mark's Family Medicine
a division of Utah HealthCare Institute