Palliative Care for the Hospitalist

WE'RE HERE TO HELP

BETTER EARLY THAN LATE

Richard E Butin, MD FACP FAAHPM

Disclosure Statement

DR. BUTIN- NO RELEVANT FINANCIAL RELATIONSHIPS TO DISCLOSE

"There's no easy way I can tell you this, so I'm sending you to someone who can."

Basic Format

Palliative (Supportive) Care
- What it is, what is offered, when to call

Communication

Hospice
- What it is, what is offered, when to call, ow to call

Questions

Objectives

At the completion of this exercise, the learner will be able to:

Describe patient criteria for a Palliative Care consult

Recall and appreciate various strategies for effective communication in sensitive and end of life situations

Differentiate between Palliative Care and Hospice

Retain and be able to access multiple quick references to use for primary palliative care

Feel more comfortable leading a family meeting

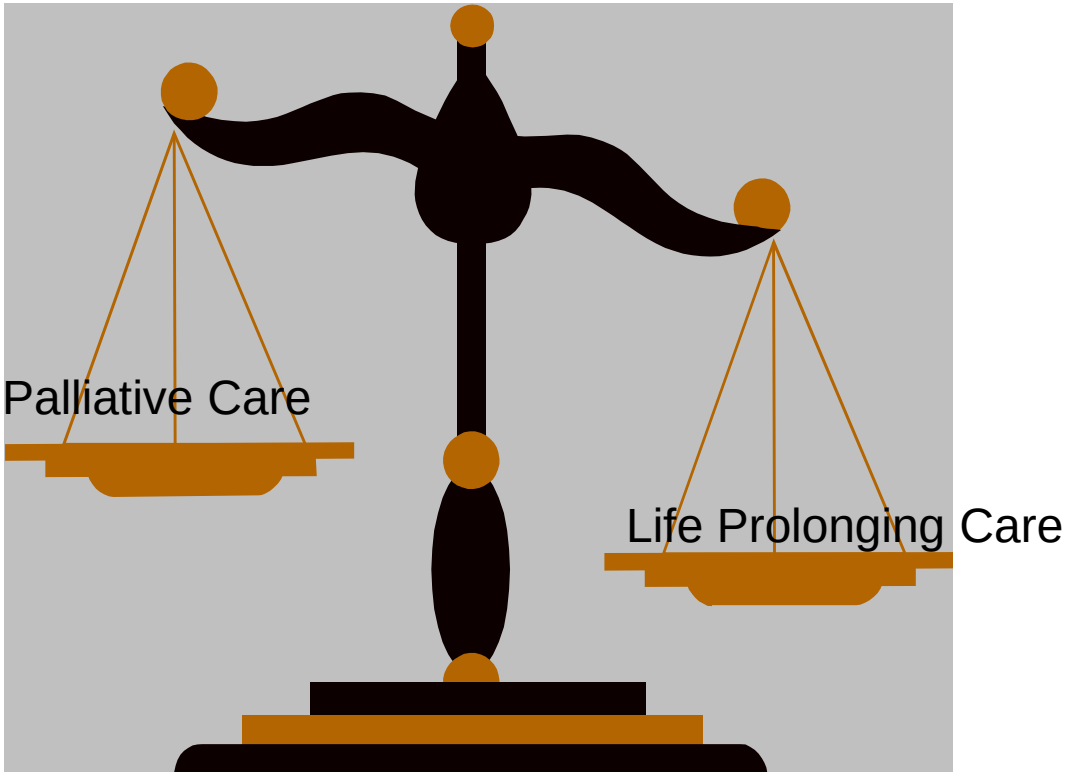
ACGME - 2022

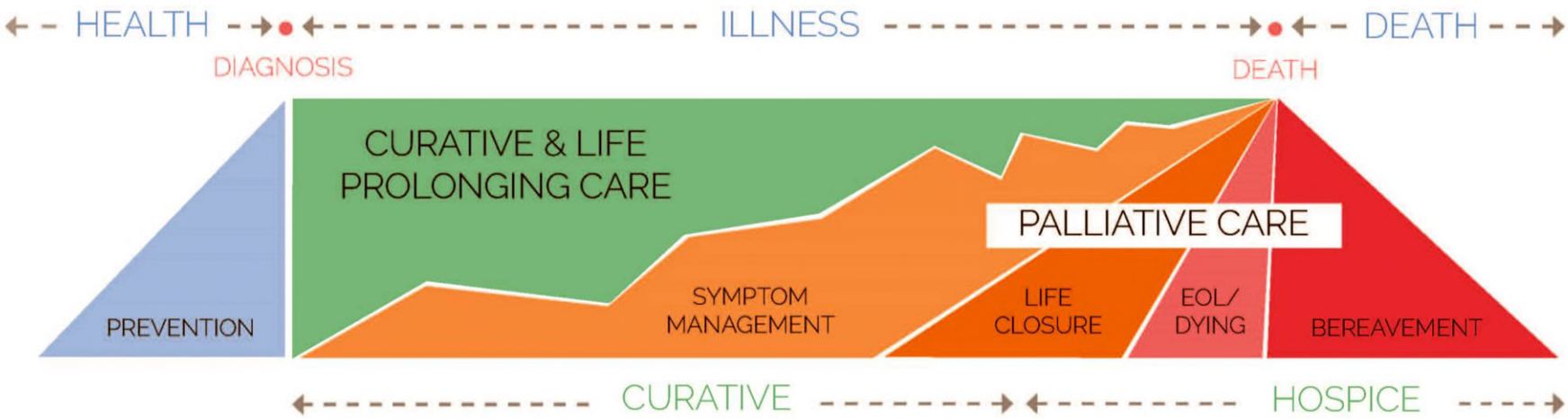
ACGME requirements for IM programs:

"**Residents must demonstrate a level of expertise in the knowledge of** the broad spectrum of clinical disorders seen by an internist, including the core content of GIM, which includes the IM subspecialties, the multidisciplinary subspecialties of geriatric medicine, **hospice and palliative medicine**, and addiction medicine, and neurology."

"**The educational program for all residents must include**….clinical experiences in geriatric medicine, **hospice and palliative medicine**, addiction medicine, emergency medicine, and neurology."

Restoring the Balance




HEALTH
ILLNESS
DEATH
DIAGNOSIS
DEATH
CURATIVE & LIFE PROLONGING CARE
PALLIATIVE CARE
PREVENTION
SYMPTOM MANAGEMENT
LIFE CLOSURE
EOL/ DYING
BEREAVEMENT
CURATIVE
HOSPICE

Definition of Palliative Care

The World Health Organization (WHO)

"an approach that **improves the quality of life** for patients and their families facing serious illnesses by **preventing and relieving suffering** through the assessment and treatment of **pain and other symptoms – physical, psychosocial, and spiritual**.

It is applicable at any stage of a serious illness, can be provided alongside curative treatment"

https://www.who.int/news-room/fact-sheets/detail/palliative-care

Case History

88 year old widow, ambulatory nursing home resident, fell out of bed and has hip pain and a foreshortened, slightly externally rotated right leg.

PMH: Alzheimer's dementia, inoperable CAD, PAD, GERD causing chest pain and multiple admissions, osteoporosis with multiple compression fractures causing chronic back pain

Social history- 65 year old DPOA daughter lives in Wichita and has health issues, comes to KC once a month.

Workup reveals femoral neck fracture

Palliative Care team

Interdisciplinary Team (IDT)

- Advanced Nurse Practitioner (ANP)
- Physician
  - Medical Director
  - Residents
- Spiritual Health Services (Pastoral Care)
- Social work services
- Pharmacist

Palliative medicine

Incorporates seven major skills:

- communication
- decision making
- management of disease-related complications
- symptom control
- psychosocial and spiritual care
- care of the dying
- coordination of care or continuity

Palliative Care

Palliative Care

- is not just pain therapy
- is not just for cancer
- is not just end-of-life care

Palliative Care

- is care for the end of life
- not just at the end of life.

We Can Help
The Appropriate Consult

Potentially life limiting illness:

- Cancer
- Brain Injury – anoxic, traumatic
- End Stage Liver Disease/ Cirrhosis
- Chronic Kidney Disease/ ESKD
- COPD
- Heart Failure
- Dementia

We Can Help
The Appropriate Consult

Multiple hospitalizations

Uncertain prognosis, goals of care

Family distress impairing surrogate decision-making

Metastatic cancer

Code blue history

Multi-organ failure

Difficult symptom control

Previous hospice patient

Request for comfort care or hospice information

Patient or family spiritual or psychological distress

ICU admission

We Can Help
The Appropriate Consult

Life-limiting illness

Likely benefit from end-of-life discussion

Goals of Care issues

The Surprise Question

The Surprise Question

"Would you be surprised if this patient were to die in the next year?"

JAMA Intern Med. Published online October 03, 2016. doi:10.1001/jamainternmed.2016.5928

“No, I would not be surprised”

Assess:

- symptoms, distress
- understanding of the underlying illness, treatment options, and prognosis
- decision-making capacity (DMC)

Elicit patient’s care preferences and values.

Engage in honest conversations about prognosis and expectations.

Advance Directive – review or introduce, and is it available in EMR

Consider a palliative care consultation.

Consider if and when a hospice referral might be appropriate.

Appropriate consult- early

Before

- terminal phase of illness
- alternatives have been exhausted
- patient is highly symptomatic
- in social disarray
- family crisis

We Can Help
The Appropriate Consult

Most common Consultation reasons:

Goals of Care discussion

Assess decision-making capacity

Advance Directive

Plan of Care (e.g. resuscitation status)

Family meetings

Symptom management
Quality of Life

Pain

Dyspnea

Nausea

Constipation

Anorexia

Fatigue

Depression

Anxiety

Drowsiness

Secretions

Delirium

Tasks for

Palliative Medicine (hospital)

- Align expectations
  - discussions on goals of care
  - communication (patient, relatives, treating team)
  - Evaluate and make recommendations for symptom management
  - advance care planning / health proxy

Hospice (home / nursing home)

- Manage dying process
  - attention to co-morbidity, manage symptoms
  - advance care planning / health proxy
  - End of life adjustments if agreement (deprescribing, nutrition/hydration)

Communication

Difficult conversations

- Goals of Care
- Delivering bad news
- Conflict
- Grief

Family meetings

Why Communication Skills?

46 percent of physicians report not knowing what to say during conversations with seriously ill patients

29 percent felt they received the necessary communication skills training to break difficult news, explore goals of care and navigate end-of-life decisions

The John A. Hartford Foundation 2016

Communication strategies

Ask, Tell, Ask

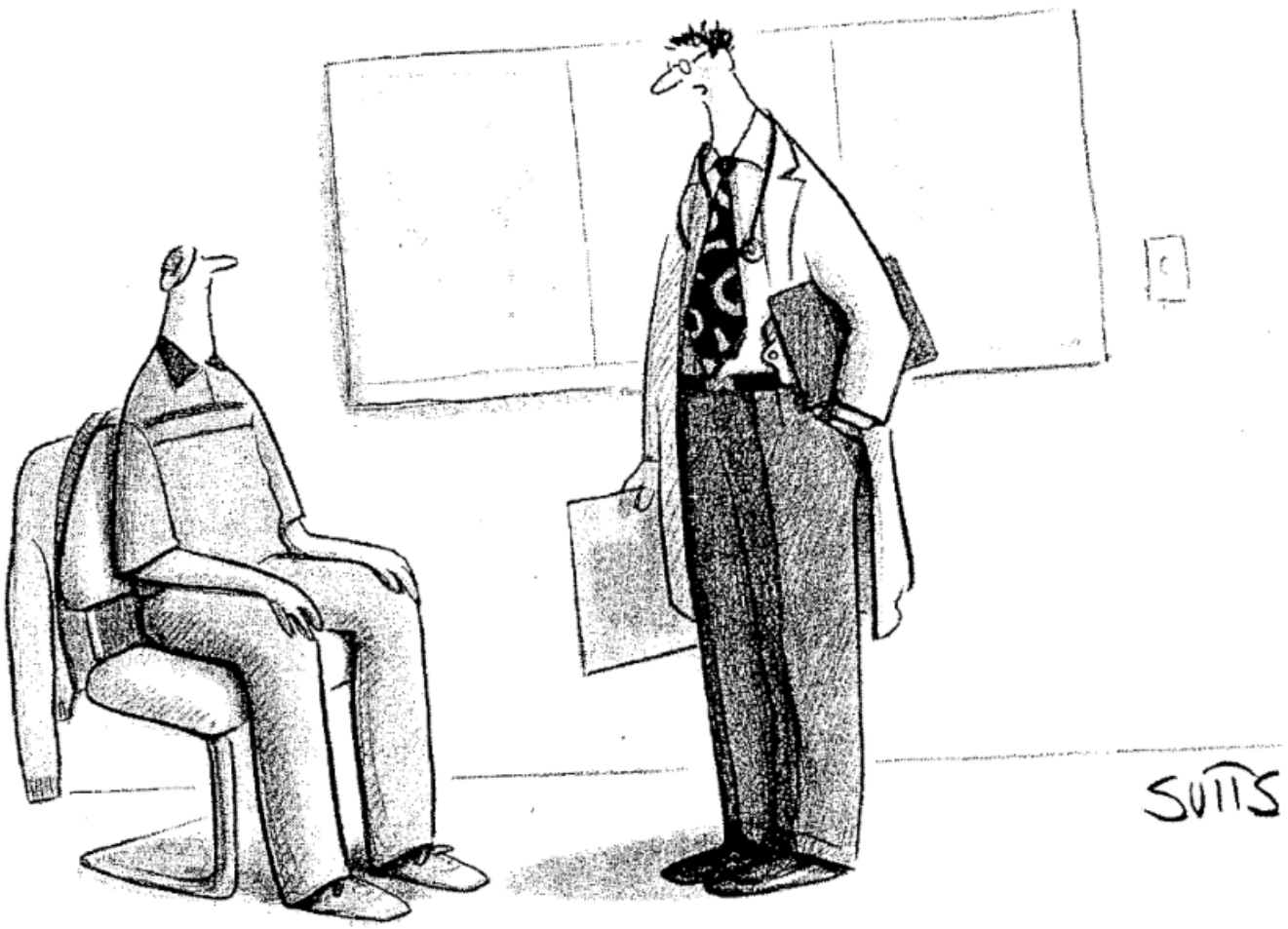
Wish, Hope, Worry

Back A, Arnold R, Quill T. Hope for the best, and prepare for the worst. *Ann Intern Med*. 2003;138(5): 439-443

The “Ask-Tell-Ask” Technique

- **Ask** the patient what his or her understanding of illness is. Explore their hopes and fears/concerns. After you have heard,
- **Tell** the patient new information that adds to what they already know.
- Finally **Ask** them what they understand from what you have told them. Clarify their goals and expectations before any decision making discussion.

https://www.endoflifeessentials.com.au/



"Anyhoo, it's malignant."

Delivering bad news

"There's no easy way I can tell you this, so I'm sending you to someone who can."

The Conversation: Who and Where?

- Poor prognosis
- New diagnosis
- Frequent admissions
- When the topic comes up

- Primary Care office
- Emergency Room
- ICU
- Hospital room

Fostering Advance Directive Discussions

- Make it routine
  - I'm not sure if we've talked about this…
  - This is something I discuss with all my patients
  - Speaking of that…
  - Since you mentioned…
  - Let me ask you about that…
  - While your (family member is here) let me ask…
  - It would be helpful to me to know…

Delivering Bad News
S-p-i-k-e-s

SPIKES protocol

Setting (timing, others present)

Perception ((patient's) of condition and seriousness)

Invitation from patient to receive information and how

Knowledge- giving medical facts

- Pause……

Emotions and empathy as patient responds

Strategy and summary

SPIKES - invitation

Would it be alright if I shared _____with you at this time?

It would help me to know the manner in which you'd like me to discuss this with you…..

How much information would you like me to give you about your diagnosis and treatment?

I know we have discussed this before. With the new information I have today, tell me how you would like this to go. Would you like me to give just the main points, or would you prefer all the details now, or perhaps later?

Responding to emotional cues The NURSE mnemonic

N - Name it "...it sounds like you've been worried about what's going on..."

U - Understand the core message: "...if I understand you correctly, you are worried about what to say to your family and how they will react..."

R - Respect /Reassurance at the right time: "...I'm really impressed that you've continued to be independent ...".

S - Support: "... would you like me to talk to your family about this..."

E - Explore: "... I notice that you're upset, can you tell me what you're thinking?"

The NURSE mnemonic has been reproduced from Back A, Arnold R, Tulsky J. Mastering communication with seriously ill patients: balancing honesty with empathy and hope. Cambridge University Press; 2009 Mar 2.

Conflict
the angry patient or family

Anger – a response/ signal

- We are being hurt or disrespected
- Our rights are being violated
- Our needs/ wants are not being met

Conflict
the angry patient or family

Strategies for constructive response

- Take your own pulse
- Remember your mission
- Mediation – open, principled
- Do not debate
  - Moves for the moral high ground
  - Tends to focus on why you are right

Grief- what to say

"I can't imagine….. This must be….."

say you were thinking about the grieving person or the one they lost

say the name of the one they lost. (Grieving people love hearing it from the lips of someone else)

"I completely understand if the timing is not good for…."

– Don't assume there is a timeline to grief. An email a year after a loss could be more meaningful than one a week later.

– Remember the bereaved on holidays, birthdays, anniversaries or any day that you know has special meaning

Patrick O'Malley, Gettingg Grief Right

Grief- not so helpful

‘my thoughts and prayers are with you’

‘Let me know if there is anything I can do’

two phrases that are said so often that the words have lost meaning

What NOT to say

These phrases imply that grief has a timetable
-“Time heals all wounds”
-“You have to move on”
-“Grief happens in stages”
-“I hope you find closure”

These phrases are by-products of a culture that rewards positivity:
-“He wouldn’t want you to be sad”
-“It’s important to stay busy and productive”
-“This will make you stronger”
-“You have your whole life ahead of you”
-“At least … you’re young enough… to have another child/remarry”

These religious thoughts might imply that a faithful person should not mourn:
-“God doesn’t give you more than you can handle”
-“God has a plan”
-“Everything happens for a reason”
-“He/she is in a better place”
-“It was her/his time to go”

Patrick O’Malley, Getting Grief Right

What to say

“I don’t know how you and Suzy met. Can you tell me?”
“I know the two of you loved to travel. What was your favorite trip?”
“What do you miss most about him?”
“How are you doing today?”
“We’ve never really talked about the day it happened. I’d like to hear about it, if you’re able.”
“I am sorry I did not get to meet your dad. I would love for you to tell me something about him.”

Bring up your own memories

Offer to listen to a grieving person’s story. A bereaved person might be looking for a safe set of ears, a place for the story to land

make sure they know that the one they lost has not been forgotten

Patrick O’Malley, Getting Grief Right

Common family conference discussion points

Diagnosis

Extent of disease

Nature of Illness

Explanation of symptoms

Prognosis

Code status

Goals of treatment

Handling of emergencies

Home care issues

Community resources

Options for terminal care

Financial concerns

Unsettled legal matters

Emotional needs

Concerns about coping with death at home

Funeral arrangements

Clayton, et al *J Clin Oncol*, 2007 Feb 20;25 (6):715-722

Patient Centered Care

Establish patient values and preferences

Communicate prognosis

Goals of care

Plan of care consistent

I Want Everything Done

Goals of Care discussion

- Let's talk about what "everything" is
- Let's try and figure out what (s)he would want
- We will do everything:
  - Beneficial
  - Likely to help
  - Reasonable
  - That will possibly help

Fostering Advance Directive Discussions

Elicit important values

- Is there anything you are worried about
- Tell me how this pain/cancer/illness has affected your life
- What makes life worth living for you
- What makes life NOT worth living for you
- What are your hopes for the future
- What is your goal for a full code

Fostering Advance Directive Discussions

Address a limited number of issues

- CPR
- Artificial nutrition and hydration

Complete documents

Review/update documents regularly

Goals of Care
People have different preferences

- Want all forms of support no matter what
- Want very limited contact with the health care system
- Want life support if thought useful as a “bridge” to health but wouldn’t want to get stuck

- Do you know which kind of person you are?
- So, based on this kind of person, and knowing what I know about your medical condition, let me translate….

CPR

The only medical procedure/ treatment that requires an order to be withheld

DNR does not mean “do not care” or “do not treat”

Summary- About 15% (1 in 6 patients)

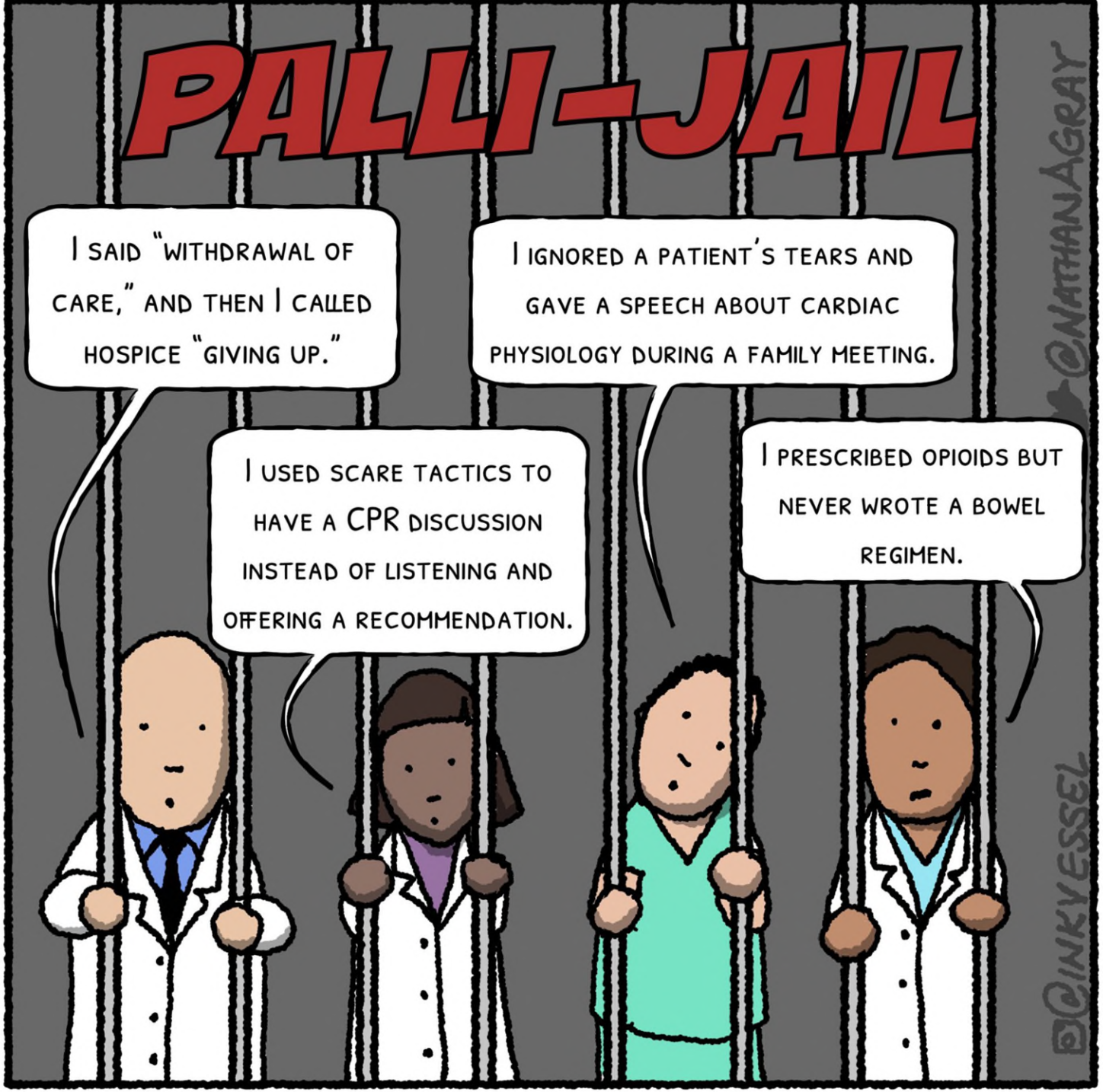
- Co-morbidities lessen the chances
- Risk of CPR related complications

End of Life (EoL) discussion

Avoid	Instead
If it were my mother	
I'm certain	In my experience
Withdrawal of "care"	Withdraw treatment
I'm sorry	I wish
Everything	Beneficial

What Not to Say

Pull the plug
(patient is) Going palliative
(patient is) Non-compliant
(We are going to) withdraw care
Patient failed (chemo, the treatment)
(There's) Nothing more we can do
(We want) "everything" done
She's a fighter (language of war) Battle … a battle you can't win
The patient is a DNR
Giving up


PALLI-JAIL
I SAID "WITHDRAWAL OF CARE," AND THEN I CALLED HOSPICE "GIVING UP."
I USED SCARE TACTICS TO HAVE A CPR DISCUSSION INSTEAD OF LISTENING AND OFFERING A RECOMMENDATION.
I IGNORED A PATIENT'S TEARS AND GAVE A SPEECH ABOUT CARDIAC PHYSIOLOGY DURING A FAMILY MEETING.
I PRESCRIBED OPIOIDS BUT NEVER WROTE A BOWEL REGIMEN.
@NATHANAGRAY
@INKYESSEL

Hospice

What is Hospice?

A ***philosophy*** of care for dying patients and their families

Hospice is not a place!

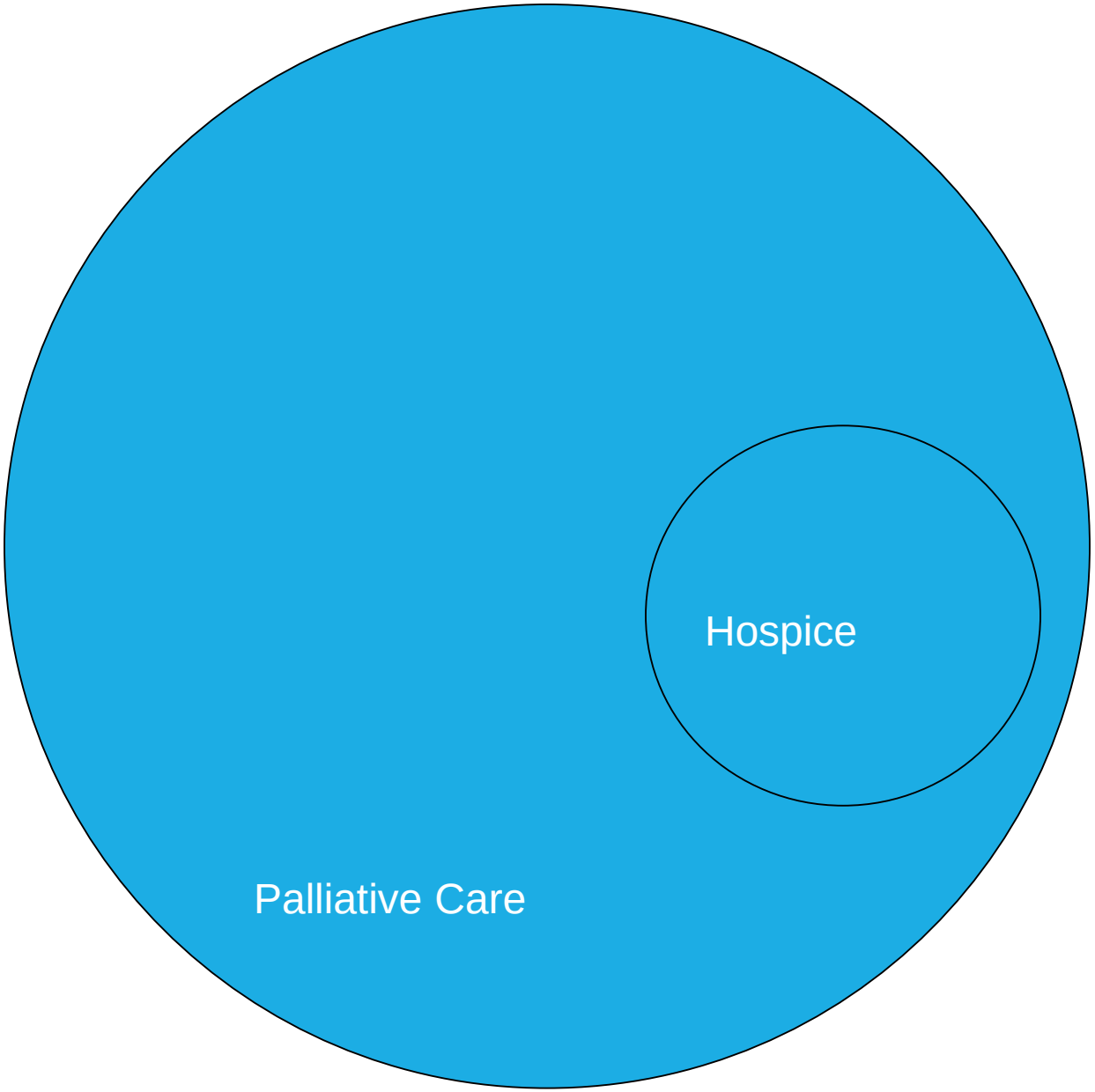
Comparing Hospice vs. Palliative Care

Hospice

- Prognosis 6 months or less
- Focus on comfort care
- Medicare hospice benefit
- Out of hospital

Palliative Care

- Life limiting illness
- May be combined with curative care
- Independent of payor
- Inpatient emphasis currently


Hospice
Palliative Care

Daily Medicare Reimbursement Rate* (By Service Type)

Daily Rates for FY 2025 beginning October 1, 2024:

Routine Home Care (Days 1-60): $224.52

Routine Home Care (Days 61+): $176.92

Continuous Home Care (Full Rate): $1,618.59 (equivalent to $67.44 per hour) for 24 hours of care during a crisis

Inpatient Respite Care: $518.78

General Inpatient Care: $1,170.04

Medicare Hospice Benefit

- Eligibility criteria- Medicare eligible and:
  1. Two physicians certify prognosis of less than 6 months assuming "*the terminal illness runs its usual course*".
  2. Treatment goals are palliative rather than curative.
  3. A physician is willing to be the physician of record.

- **Note!!** Hospice agencies may not use DNR status as criteria for eligibility. (CMS)

What services are provided to patients and their families?

Provide medications, medical supplies and equipment

Manage pain and symptoms

Assist with emotional, psychosocial and spiritual aspects of dying

Instructs family/caregivers on care issues

Deliver special services (speech, PT)

Available short term inpatient care

Bereavement care and counseling for survivors

Hospice Enrollment: Myths vs Facts

Myths	Facts
Must agree to DNR	Code status not required
No hospitalizations	Allowed with coordination
Must stop chemo/radiation	Palliative therapy allowed
No research participation	Research permitted
One MD certifies prognosis	Two MDs certify prognosis

Palliative Care vs Home Health

Palliative Care	Home Health
Focus: Quality of life, symptom relief at any stage	Focus: Recovery/rehabilitation after illness or injury
Can be given with curative treatments	Usually short-term, for homebound patients (Medicare)
Settings: home, hospital, nursing facility	Delivered specifically in the home
Team: doctors, nurses, social workers, chaplains, pharmacists	Team: nurses, therapists, aides
Services: symptom management, emotional & spiritual support, advance care planning	Services: wound care, IV therapy, rehab, personal care tasks

Home Palliative Care vs Home Health Visit Frequency

PALLIATIVE CARE	HOME HEALTH
Variable based on needs	Episodic care
Can become more frequent	Improves over time
Involves different professionals	Based on doctor's orders
Provides 24/7 support	Specific criteria for visits

Discussing Hospice with Patients/Families

- First: Help patients identifyimportant end of life goals, typically
  - Home, family, symptom control
- Second: Present Hospice care as a means by which these goals can best be met.
- Third: Stress that having trained eyes and ears in the home on a regular basis can assist you in doing a better job to help meet the patient's goals.
- Fourth: Suggest an informational visit by a hospice agency to the patient's home.

General Predictors Applicable to all Diagnoses

Underlying chronic life-limiting disease

Functional status

- Progressive loss of function (ADL's)

Nutritional status

- Weight loss
- Insufficient intake

Performance status *

Karnofski perfomance status scale

Palliative Performance Scale (PPS)

Eastern Cooperative Oncology Group Performance status scale

ECOG performance status

Grade	Description of patient
0	Fully active, able to carry on all predisease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work
2	Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any self-care; totally confined to bed or chair
5	Dead

MDedge News

Source: Eastern Clinical Oncology Group

Palliative Performance Scale (PPSv2)

version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Prognostic Indicators: Cancer

3 months or less

In bed >50% time and getting worse

Hypercalcemia (except new myeloma or breast cancer)

Dyspnea related to the cancer

Carcinomatous Meningitis or Malignant Pericardial Effusion

Liver Metastases with jaundice

Brain metastases

Malignant ascites or pleural effusion

Most metastatic solid cancers in which there is no planned, or ineffective, systemic treatment

Test question

Pick the language that, instead of expressing compassion, empathy and bringing comfort to the patient and family, can have unintended consequences:

- -I want to give you the best care possible (until the end)
- -I'll do everything I can to help you maintain your independence
- -I will focus my efforts on treating your symptoms
- -Do you want us to do everything possible?
- -I want to help you live meaningfully in the time that you have

Important Resource

Fast Facts – Palliative Care

- https://www.mypcnow.org/

PC NOW PALLIATIVE CARE NETWORK OF WISCONSIN

#516

Young Carers of Patients with Serious Illness

By Lucas Perri BHSc-1(1), Afolasade Fakolade PhD(2), Dr. Warren Lewin MD(3)

#515

The Anorexia-Cachexia Syndrome: Pharmacologic Management

By Jacqueline Sheehan MD1, Sara Radparvar PharmD2, Mollie Biewald MD1

#514

The Importance of Sitting When Caring for Patients with Serious Illness

By Sean Marks MD, Jonathan Gully MD, James Deming MD

Vital Talk

https://www.vitaltalk.org/vitaltalk-apps/

This form may be photocopied and distributed Revised Oct. 200

Durable Power of Attorney for Healthcare Decisions

■ *Take a copy of this with you whenever you go to the hospital or on a trip* ■

It is important to choose someone to make healthcare decisions for you when you cannot make or communicate decisions for yourself. Tell the person you choose what healthcare treatments you want. The person you choose will be your agent. He or she will have the right to make decisions for your healthcare. If you DO NOT choose someone to make decisions for you, write NONE on the line for the agent's name.

I, _____, SS#_____ (optional), appoint the person named in this document to be my agent to make my healthcare decisions.

This document is a Durable Power of Attorney for Healthcare Decisions. My agent's power shall not end if I become incapacitated or if there is uncertainty that I am dead. This document revokes any prior Durable Power of Attorney for Healthcare Decisions. My agent may not appoint anyone else to make decisions for me. My agent and caregivers are protected from any claims based on following this Durable Power of Attorney for Healthcare. My agent shall not be responsible for any costs associated with my care. I give my agent full power to make all decisions for me about my healthcare, including the power to direct the withholding or withdrawal of life-prolonging treatment, including artificially supplied nutrition and hydration/tube feeding. My agent is authorized to

- Consent, refuse, or withdraw consent to any care, procedure, treatment, or service to diagnose, treat, or maintain a physical or mental condition, including artificial nutrition and hydration;
- Permit, refuse, or withdraw permission to participate in federally regulated research related to my condition or disorder
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other healthcare organization; and, employ or discharge healthcare personnel (any person who is authorized or permitted by the laws of the state to provide healthcare services) as he or she shall deem necessary for my physical, mental, or emotional well -being;
- Request, receive, review, and authorize sending any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; and execute any releases that may be required to obtain such information;
- Move me into or out of any State or institution;
- Take legal action, if needed;
- Make decisions about autopsy, tissue and organ donation, and the disposition of my body in conformity with state law; and
- Become my guardian if one is needed.

In exercising this power, I expect my agent to be guided by my directions as we discussed them prior to this appointment and/or to be guided by my Healthcare Directive *(see reverse side)*.

If you DO NOT want the person (agent) you name to be able to do one or other of the above things, draw a line through the statement and put your initials at the end of the line.

Agent's name _____ Phone _____ Email_____

Address_____

If you do not want to name an alternate, write "none."

Alternate Agent's name _____ Phone _____ Email_____

Address_____

Execution and Effective Date of Appointment

My agent's authority is effective immediately for the limited purpose of having full access to my medical records and to confer with my healthcare providers and me about my condition. My agent's authority to make all healthcare and related decisions for me is effective when and only when I cannot make my own healthcare decisions.

SIGN HERE for the *Durable Power of Attorney* and/or *Healthcare Directive* forms. Many states require notarization. It is recommended for the residents of all states. Please ask two persons to witness your signature who are not related to you or financially connected to your estate.

Signature _____ Date_____

Witness_____ Date _____ Witness_____ Date_____

Notarization:

On this _____ day of_____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of_____, State of _____, on the date written above.

Notary Public_____

Commission Expires_____

Healthcare Treatment Directive

I, _____, SS# _____ want everyone who cares for me to know what healthcare I want.
(optional)

I always expect to be given care and treatment for pain or discomfort even if such care may affect how I sleep, eat, or breathe.

I want my dying to be as natural as possible. Therefore, I direct that no treatment (including food or water by tube) be given just to keep my body functioning when I have

- a condition that will cause me to die soon, or
- a condition so bad (including substantial brain damage or brain disease) that I have no reasonable hope of achieving a quality of life that is acceptable to me.

An acceptable quality of life to me is one that includes the following capacities and values. (Describe here the things that are most important to you when you are making decisions to choose or refuse life-sustaining treatments.)

_____

_____

_____

_____

Examples:
- recognize family or friends
- feed myself
- make decisions
- take care of myself
- communicate
- be responsive to my environment

I want my doctor to try treatments on a time-limited basis when the goal is to restore my health or help me experience a life in a way consistent with my values and wishes. I want such treatments withdrawn when they cannot achieve this goal or become too burdensome to me.

Among the time-limited treatments I would not agree to under any circumstances are the following: _____

_____

_____

Examples:
- resuscitation (CPR)
- food or water by tube
- antibiotics
- dialysis
- chemotherapy
- surgery
- ventilator
- transfusions

In facing the end of my life, I expect my agent (if I have one) and my caregivers to honor my wishes, values, and directives.

Be sure to sign the reverse side of this page even if you do not wish to appoint a Durable Power of Attorney for Healthcare Decisions

If you only want to name a Durable Power of Attorney for Healthcare Decisions, draw a large X through this page.

Talk about this form and your ideas about your healthcare with the person you have chosen to make decisions for you, your doctors, family, friends, and clergy. Give each of them a completed copy.

You may cancel or change this form at any time. You should review it often. Each time you review it, put your initials and the date here. _____

This document is provided as a service by the Center for Practical Bioethics.
For more information, call the Center for Practical Bioethics 816-221-1100
E-mail – *bioethic@practicalbioethics.org* • Web site – *www.practicalbioethics.org*

OUTSIDE THE HOSPITAL DO-NOT-RESUSCITATE (OHDNR) ORDER

I, _____, authorize emergency medical services personnel to
(name)
withhold or withdraw cardiopulmonary resuscitation from me in the event I suffer cardiac or respiratory arrest. Cardiac arrest means my heart stops beating and respiratory arrest means I stop breathing.

I understand that in the event that I suffer cardiac or respiratory arrest, this OHDNR order will take effect and no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care and medical interventions, such as intravenous fluids, oxygen or therapies other than cardiopulmonary resuscitation such as those deemed necessary to provide comfort care or to alleviate pain by any health care provider (e.g. paramedics) and/or medical care directed by a physician prior to my death.

I understand I may revoke this order at any time.

I give permission for this OHDNR order to be given to outside the hospital care providers (e.g. paramedics), doctors, nurses, or other health care personnel as necessary to implement this order.

I hereby agree to the "Outside The Hospital Do-Not-Resuscitate" (OHDNR) Order.

Patient – Printed or Typed Name	Date
Patient's Signature or Patient Representative's Signature	Date

REVOCATION PROVISION

I hereby revoke the above declaration.

Patient's Signature or Patient Representative's Signature	Date

I AUTHORIZE EMERGENCY MEDICAL SERVICES PERSONNEL TO WITHHOLD OR WITHDRAW CARDIOPULMONARY RESUSCITATION FROM THE PATIENT IN THE EVENT OF CARDIAC OR RESPIRATORY ARREST.
I affirm this order is the expressed wish of the patient/patient's representative, medically appropriate and documented in the patient's permanent medical record.

Attending Physician's Signature **(Mandatory)**		Date
Attending Physician – Printed or Typed Name	Attending Physician's License No.	Attending Physician's Telephone No.
Address – Printed or Typed		Facility or Agency Name

THIS OHDNR ORDER SHALL REMAIN WITH THE PATIENT WHEN TRANSFERRED OUTSIDE THE HEALTH CARE FACILITY.

Emergency Medical Services personnel shall not comply with an outside the hospital do-not-resuscitate order when the patient or the patient's representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated or if the patient is or is believed to be pregnant.

Statutory citation 190.600-190.621 RSMo
9/07

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Kansas – Missouri Transportable Physician Orders for Patient Preferences (TPOPP)

This Medical Order set is based on the patient's current medical condition and preferences. Any section not completed indicates full treatment for that section. The original form need not be present at the time of emergency. A copied, faxed or electronic version of this form is valid.

Last Name:	First Name:	Middle Initial:
Date of Birth:	Last 4 SSN:	*(For Patient Identifiers)*

A. CHECK ONE

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
If patient is not in cardiopulmonary arrest, follow orders in B and C.

☐ **Attempt Resuscitation/CPR**
(Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation**
(DNAR/no CPR/Allow Natural Death)

B. CHECK ONE

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

☐ **Full Treatment.**
In addition to treatment described in **Comfort Measures Only** and **Selected Additional Interventions** *(see below)*, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.
TREATMENT GOAL: ATTEMPT TO PROLONG LIFE BY ALL MEDICALLY EFFECTIVE MEANS.

☐ **Selected Additional Interventions.**
In addition to treatment described in **Comfort Measures Only** *(see below)*, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.
TREATMENT GOAL: ATTEMPT TO RESTORE FUNCTION WITH TREATMENTS FOR REVERSIBLE CONDITIONS.

☐ **Comfort Measures Only.**
Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location.
TREATMENT GOAL: ATTEMPT TO MAXIMIZE COMFORT THROUGH SYMPTOM MANAGEMENT ONLY.

Additional Orders: _____

C. CHECK ONE

MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.

☐ Long term medically administered nutrition, including feeding tubes.
☐ Medically administered nutrition, including feeding tubes, for trial period: _____
☐ No medically administered nutrition, including feeding tubes.

Additional Orders: _____

D. CHECK ALL THAT APPLY

INFORMATION AND SIGNATURES

Discussed with:
☐ Patient ☐ Agent/DPOA healthcare ☐ Parent of minor ☐ Legal guardian
☐ Health care surrogate ☐ Other *(specify)*: _____

Signature of patient or recognized decision maker *(All fields required)*
By signing this form, the recognized decision maker acknowledges that this request regarding above treatment measures is consistent with the known desires, and with the best interest, of the individual who is the subject of the form.

Print name:	Signature:	Relationship:
Address:		Phone:

Signature of authorized healthcare provider *(All fields required)*
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print name of authorized provider and Physician:	Phone:
Signature of authorized provider:	Date:

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

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