Tamra K. Deuser, MD Memorial Lecture
Supported by the TAFP Foundation Board of Trustees

Tamra K. Deuser, MD
October 3, 1961 – July 7, 2015

In July of 2015 Dr. Tamra Deuser passed away after a battle with cancer. To honor her memory and commitment to family medicine the TAFP Foundation created the Dr. Tamra K. Deuser Endowment to fund CME lectures at TAFP conferences on end-of-life care. We remember her by naming that lecture the Tamra K. Deuser Memorial Lecture.

Tamra grew up in Austin and had a successful career in consumer products manufacturing before becoming a physician. She received her medical degree from the University of Tennessee Health Science Center College of Medicine and completed her residency with the San Jacinto Methodist Hospital Family Medicine Residency Program. She began practicing in the Flower Mound area in 2002 and continued to see patients until 2014.

Not long after completing residency Tamra became involved with TAFP. She represented the Dallas Chapter for many years and served on numerous committees and commissions including as Chair of the Commission on Health Care Services and Managed Care. The staff and her colleagues were honored by the amount of time she dedicated to family medicine when she knew that her time was limited. She was elected to the TAFP Board of Directors in 2013 after our governance change and served as Parliamentarian 2014-15.

Having gone through cancer treatment herself, she knew the importance of palliative care and wanted to share her experiences from the patient perspective. At the 2015 C. Frank Webber Lectureship, she joined Dr. Clare Hawkins in a discussion on palliative care. The lecture was both well received and incredibly important to her. She had hoped to participate in more CME events but that was not to be.

In honor of Dr. Deuser's life and work, the TAFP Foundation began fundraising in the fall of 2015. The endowment has supported a lecture on end-of-life care each year since 2016.

Advance Care Planning in Family Medicine

TAFP Annual Session & Primary Care Summit
October 28, 2022

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Disclosure

- Dr. McGregor, Dr. Kumar, and Dr. Morphew have no financial relationships with any ineligible organizations or commercial interests.

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GOALS AND OBJECTIVES

- Define advance care planning and its role in family medicine.
- Elucidate the legal hierarchy of medical decision making in the state of Texas.
- Be familiar with commonly used advance care planning documents.
- Describe a method to initiate advance care planning conversations in family med patients.

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ADVANCE CARE PLANNING

- A process of informed decision-making that acknowledges the person's autonomy and right of choice.
- A conversation between an individual, family members and health care providers.
- Planning ahead to specify individual treatment choices when very ill or near death.
- ACP is initiated while the resident is of sound mind and not under stress.
- Process that may conclude with legal documentation known as Advance Directives.

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Case 1

- 64-year-old male with past medical history of hemophilia and moderately differentiated mucinous adenocarcinoma who presents to the hospital with a large bowel obstruction. He is deemed to need a surgery. He has expressed that he would like to complete advance care planning documents in the event he has complications during surgery.
- He lives alone and is legally divorced.
- He has one son (age 18) who is joining college and currently lives with his mother.
- He has a 96-year-old mother, a sister, and a brother.

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Question 1: If this patient loses capacity to make his own medical decisions, who is legally considered to be his medical decision maker in the state of Texas?

- A. Mother
- B. Ex-wife
- C. Son
- D. Brother
- E. His attorney

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Case 2

- 64 y/o male with past medical history of prostate cancer, CVA with residual weakness and receptive/expressive aphasia. He was deemed to lack capacity to make medical decisions.
- Patient arrived from an LTACH. He is not married and has an older daughter whom he is estranged with limited contact with. (1-2 times/year). He has 4 siblings who are all involved in his care.
- *One of his sisters reports she has a statutory durable power of attorney that list her as his decision maker.*

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Question 2: If this patient loses capacity to make his own medical decisions, who is legally considered to be his medical decision maker in the state of Texas?

- A. Brother
- B. Sister with the Statutory durable power of attorney
- C. Estranged daughter
- D. Majority opinion of siblings
- E. None of the above

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Legal Hierarchy of Surrogate Decision Making

Varies from state to state in US

In Texas:

- Competent Adult
- Legal Guardian
- Designated MPOA
- Spouse
- Adult Children (waiver of other children or majority) or majority of the patient's reasonably available adult children
- Parent (if living)
- Family Member, Friend, Clergy

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Advance Care Planning Documents

- Advance Directive
- Medical Power of Attorney (MPOA)
- Statutory Durable Power of Attorney (SDPOA)
- Directive to Physicians
- Living Will
- Out of Hospital Do-Not-Resuscitation
- Medical Orders for Scope of Treatment (MOST)
- Physician Orders for Life-Sustaining Therapies (POLST)
- Physician Orders for Scope of Treatment (POST)

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Where to find these documents

TEXAS Health and Human Services

Services · Providers · Business · Regulations · About · News · Contact

Home > Search Regulations > Forms > Advance Directives

Advance Directives

English | Español

Available at:
www.hhs.texas.gov/regulations/forms/advance-directives

Instructions for Opening a Form

Some forms cannot be viewed in a web browser and must be opened in Adobe Acrobat Reader on your desktop system. Click here for instructions on opening this form.

ES = Spanish version available.

- Declaration for Mental Health Treatment ES
- Directive to Physicians and Family or Surrogates ES
- Medical Power of Attorney ES
- Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order
- Statutory Durable Power of Attorney ES

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Medical Power of Attorney

- Also termed as Health Care Proxy (HCP) or durable power of attorney for health care (DPAHC)
- Legal document that allows a patient to appoint someone to make healthcare decisions if/when they become incapacitated
- Can be changed or updated at any time
- Patients can limit the scope of decisions the MPOA can make
- Does not pertain to financial situations . This is DIFFERENT from a statutory durable power of attorney
- Must be witnessed by two people with multiple restrictions or notarized
- Available in English and Spanish, English only legally recognized.

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Question #3: TRUE or FALSE?

MPOA documents remain valid once a patient dies.

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Medical Power of Attorney

A person's chosen "voice" for medical decisions only in the event of incapacity of that individual

MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT
Advance Directives Act (see §166.164, Health and Safety Code)

I, ______________________ (insert your name) appoint:

Name: ______________________

Address: ______________________

______________________ Phone: __________

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

DESIGNATION OF AN ALTERNATE AGENT:
(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved annulled, or declared void unless this document provides otherwise.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Name: ______________________

Address: ______________________

______________________ Phone: __________

Second Alternate Agent

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Persons considered not legally eligible in Texas to serve as witness to formal advance care documentation

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

(1) the person you have designated as your agent;
(2) a person related to you by blood or marriage;
(3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
(4) your attending physician;
(5) an employee of your attending physician;
(6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
(7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

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Directive to Physicians <=>Advance Directive<=> "Living Will"

- Generally synonymous
- Allow patients to direct physicians about their wishes regarding life-sustaining therapies
- Most useful when a patient has a terminal or life-limiting illness
- Often also includes an option to appoint an MPOA
- Similar witness restrictions or can be notarized
- Can be changed or revoked at any time

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Advance Directives

- An individual's advance directive documentation requires:
  - Decisional capacity of the individual who understands that, in the event that they LOSE that capacity to make their own medical and/or end-of-life decisions, their chosen proxy will be tasked with making treatment decisions on their behalf
  - The individual should clarify their decisions to their proxy to avoid confusion and uncertainty
- Advance directives are only acted upon when a patient is no longer capacitated
- Advance directives are considered "fluid" and can be changed or revoked by the individual at any time of their choosing

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Directive

I ______________________, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgement of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. **(This selection does not apply to Hospice care.)**

If, in the judgement of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. **(This selection does not apply to Hospice care.)**

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Out-of-Hospital DNR Order

- Medical order by a doctor allowing patient to decline specific life-sustaining therapies outside of a hospital setting
- Does not apply in hospital (DNR or DNAR require specific orders in hospital)
- Only in the event of cardiac arrest
- Must be signed by an attending physician (in Texas)
- Patients/caregivers show the form to any healthcare professional in the event of emergency (make copies!)
- Must be witnessed or notarized

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Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

STOP DO NOT RESUSCITATE

Print Form

Person's full legal name ______ Date of birth ______ ☐ Male ☐ Female

A. **Declaration of the adult person:** I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature ______ Date ______ Printed name ______

B. **Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:**

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature ______ Date ______ Printed name ______

C. **Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication:** I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature ______ Date ______ Printed name ______

D. **Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person:** I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature ______ Date ______ Printed name ______ Lic# ______

E. **Declaration on behalf of the minor person:** I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature ______ Date ______

Printed name ______

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PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature ______ Date ______

Printed name ______ License # ______

F. **Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative:** The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature ______ Date ______ Printed name ______ Lic# ______

Signature of second physician ______ Date ______ Printed name ______ Lic# ______

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature ______ Guardian/Agent/Proxy/Relative signature ______

Attending physician's signature ______ Second physician's signature ______

Witness 1 signature ______ Witness 2 signature ______ Notary's signature ______

This document or a copy thereof must accompany the person during his/her medical transport.

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Question #4 TRUE or FALSE?

If a person has a signed **MOST** form indicating DNR in Texas, EMS personnel WILL NOT perform CPR on that person in the event of a cardiac arrest.

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MOST, POLST, and POST Documents

- Provide medical orders in line with patients' preferences if a medical emergency occurs
- Intended for patients who:
  - May be expected to die within the next 1-2 years
  - Are at risk of medical emergencies requiring ICU level care
  - Have multiple unplanned hospital admissions
  - Are frail
  - Experience progressive loss of function
- Forms are voluntary and must be approved by the patient or proxy
- Vary state-to-state
- State-specific laws regarding who can sign forms

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Texas

- Texas acknowledges a MOST form but it is not a legally recognized document
- Medical orders are acceptable for most healthcare professionals
- EMS will not honor DNR portion of form
  - Patients also need an Out-of-Hospital DNR form completed
- Other state POLST forms not recognized in Texas
- "FIVE WISHES" documents are good for goals of care conversations and honored in several other states, but NOT in TEXAS.

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HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

TEXAS MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) (FINAL 9/28/18)

First Name: Last Name:

Date of Birth: Date Form Prepared:

Follow this MOST and patient preferences first, then contact a physician. **Any section not completed implies full treatment for that section and does not invalidate the form.** Send this MOST with the patient for all transfers between treatment sites. Comfort care and dignity will be provided to all patients.

A (Check ONLY one)

PHYSICIAN RESUSCITATION ORDER: If patient does not have a pulse and is not breathing:

- ☐ **Attempt Resuscitation (CPR)** Place tube in the windpipe, electrical shocks to the chest, chest compression, and IV tubes for fluids/medications.
- ☐ **Do Not Attempt Resuscitation/Allow Natural death (DNAR/AND)** Provide physical comfort, emotional, and respectful spiritual support to patient and family. ☐ **Out-Of-Hospital-Do-Not-Resuscitate Form completed**

If patient is not in cardiopulmonary arrest, follow orders found in Sections **B** and **C**

B (Check ONLY one)

MEDICAL INTERVENTION SCOPE: If patient is unstable, has pulse and is breathing:

- ☐ **FULL INTERVENTIONS:** Transfer to a hospital, and if necessary to ICU. Use comfort and selective measures, and may add medically appropriate ICU interventions like, but not limited to, intubation/ventilator support, ICU-only medications, and dialysis.
- ☐ **SELECTIVE INTERVENTIONS:** If necessary, transfer to a hospital. In addition to comfort measures, may add interventions like intravenous antibiotics, non-invasive breathing support (BiPAP/CPAP), and fluid resuscitation.
- ☐ **COMFORT INTERVENTIONS ONLY:** Avoid hospitalization unless needed to provide comfort care. Focus on symptom control, dignity, and allowing gentle, natural death should it occur. Use comfort interventions like oral, subcutaneous, or intravenous medications (e.g., opioids), comfort foods/liquids, oxygen, and emotional/spiritual support.

ADDITIONAL ORDERS ____________________

C (Check ONLY one)

MEDICALLY ASSISTED NUTRITION/HYDRATION

Offer nutrition and hydration by mouth at all intervention levels if feasible.

- ☐ **Long-term medically assisted nutrition/hydration, including feeding tubes.**
- ☐ **Unless medically contra-indicated*, defined trial of medically assisted nutrition/hydration, including feeding tubes.** Length of trial ________ Goal ____________
- ☐ **No medically assisted nutrition.**

* In some circumstances including, but not limited to, heart, lung, liver or kidney failure, assisted nutrition or hydration may increase suffering or hasten death, and is therefore medically contraindicated.

D

DOCUMENTATION OF DISCUSSION AND SIGNATURES:

Discussed with:
- ☐ Patient (Patient has capacity)
- ☐ Health Care Agent or Decision Maker: ____________ *(Relationship, Name)*
- ☐ Court Appointed Guardian
- ☐ Others in Attendance: ____________ *(Relationship, Name)*

Rationale for these orders: (Choose all that apply)
- ☐ Living Will (Directive to Physicians and Family or Surrogates)
- ☐ Medical Power of Attorney
- ☐ Other: ____________

Physician Signature: My signature certifies both the order and preferences above and the basis for them.

X Physician Signature:	Print Physician Name:	Date:	Phone Number:

Patient or Patient's Surrogate Signature:

X Patient or Surrogate Signature:	Print Patient or Surrogate's Name, if signing:	Date:	Phone Number:

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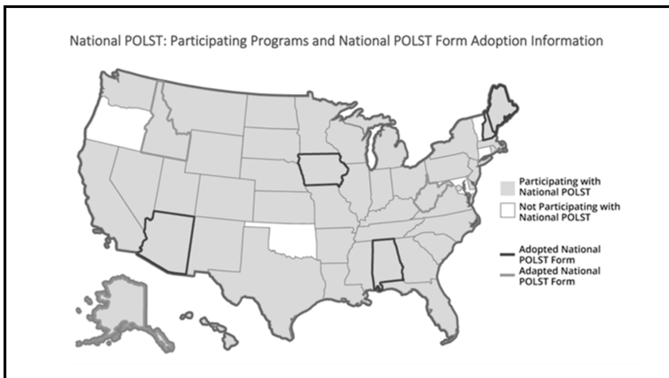

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ACP 5-Step Process

- Exploration of beliefs and values
- Knowledge of health care choices
- Discussion with family and physician
- Completion of Advance Directives
- Informing others of choices

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Tips for Initiating Advance Care Planning Discussions

- Normalize the conversation
- "Other patient/families have asked/experienced…"
- Reassurance that:
  - Autonomy will be protected
  - Proxy decision making is ONLY for periods of incapacity
  - Competent Adult
  - Legal Guardian
  - Designated MPOA
  - Spouse
  - Adult Children (waiver of other children or majority) or majority of the patient's reasonably available adult children
  - Parent (if living)
  - Family Member, Friend, Clergy

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Case 3

- You have an upcoming office visit appointment with Mr. J, a 72 yr. old man with a PMH of advanced COPD, DM2, HTN and CAD (s/p MI last year w stenting). He was recently hospitalized with acute respiratory failure for severe COPD exacerbation. He has had 4 admissions for COPD exacerbation with 2 episodes of community-acquired pneumonia in the past 7 months.
- He required BIPAP ventilation during the past 2 hospital stays for hypoxia and respiratory fatigue but was able to avoid mechanical ventilation.
- He has been very slow to recover and has not returned to his baseline, now on continuous O2 at 2-3 lpm.
- Mr. J's wife and oldest daughter are very active in his care and will be able to come to his hospital follow-up clinic appointment .
- You are concerned that his pulmonary disease is rapidly worsening despite maximal medications.
- You'd like to initiate an advance care planning conversation with Mr. J and his family during this office visit.

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PAUSE: Tool for Initiating Goals of Care/ACP

FROM: VITALTALK.ORG

- **PAUSE** – To initiate the conversation
- **ASK** – Permission & explain why
- **UNDERSTAND** – "Big picture" & values
- **SUGGEST** – Choosing a Surrogate
- **EXPECT** – Emotion & respond w Empathy

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NURSE tool for Responding to Emotion

- NAME the emotion – "It seems like you are really frustrated"
- UNDERSTAND – "Help me understand how you are feeling"
- RESPECT – "You have worked so hard to get better with this illness"
- SUPPORT – "We are here to support your choices"
- EXPLORE – "When you say___, can you tell me what you mean?"

FROM VITALTALK.org

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Medicare Advance Care Planning

- DEFINITION: Advance care planning (ACP) is the face-to-face time a physician or other qualified health care professional spends with a patient, family member, or surrogate to explain and discuss advance directives.
- REQUIREMENTS & COMPONENTS for ACP:
  - Advance care planning services should not be reported on the same date of service as critical care services (i.e., CPT codes 99291 and 99292), neonatal and pediatric critical care codes, and some intensive hospital care services.
- ACP Coding
  - 99497 First 30 minutes (minimum of 16 minutes)
  - 99498 Add-on for additional 30 minutes

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ACP Billing Codes

- Medicare reimburses for discussion of advance directives
  - It is not required that forms be completed during the encounter
- 99497 – first 30 minutes
- 99498 – each additional thirty minutes
  - Only need to do 1 minute more than the midpoint for each code
  - Important to document separately the amount of time spent in ACP activities
- Can be billed in addition to E&M codes
- Can be billed inpatient, outpatient, SNF, home
- Can be billed multiple times for each patient

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Billing $uccessfully for ACP in Office

CODE 99497	CODE 99498
ACP incl expl and discussion of adv directives such as standard forms	Each addnl 30-minute face to face with the pt/family members
Provided by physician or other qualified HC professional	Minimum 16 min do past the first 30 min documented
First 30 min face-to-face time w pt/family member or surrogate (min 16 min documented)	List separately in addn to code for primary procedure
Completion of advance directive is not an overall requirement for ACP billing	
OK TO BILL: Physicians (any specialty), licensed Clinical nurses, NPs, PAs	FROM: Amer Family Physician Advance CarePlanning (aafp.org)

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Additional Resources for ACP for Patients

- CP-Patient-Handout.pdf (aafp.org)
- Agingwithdignity.org
- Fivewishes.org/formyself/
- Advance Care Planning (aafp.org)
- TexasTalks.org
- Vitaltalk.org
- Prepareforyourcare.org
- Theconversationproject.com
- Serious Illness Conversation Guide
- https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/advance-care-planning.html

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- Advance Care planning is a fluid process and should be revisited every year
- Patients & Family expect and appreciate and value clear goals of care discussions
- The primary ACP documents accepted in Texas are: MPOA, Living will, Out of Hospital DNR
- The MOST is recognized only with TX OOH DNR in Texas
- Out of hospital DNR documents may/may not be accepted in other states
- POLST and MOST aren't accepted in TX but can be used to spark conversation
- Medicare reimburses for ACP billing
- THANK YOU FOR YOUR TIME!

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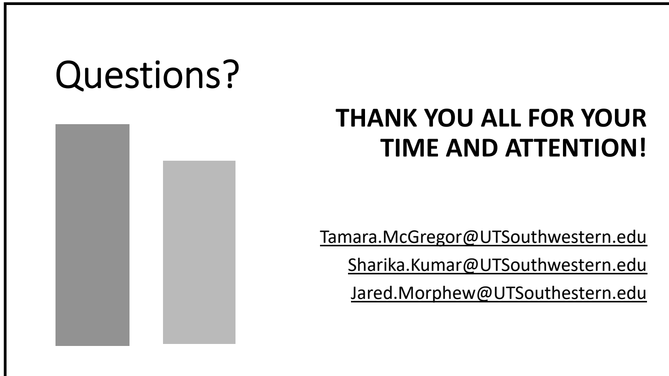

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Thank You!!

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References

- https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf/quality-monitoring-program/evidence-based-best-practices/advance-care-planning/personal-choices-advance-care-planning-presentation
- https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/advance-care-planning.html
- More references

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ACP Step 1: Explore Beliefs & Values

- Health care decisions can prolong life or not prolong life.
- Beliefs and values can guide medical decisions.
- This issue is best faced with careful consideration and not in a crisis situation.
- Consider what basic life qualities are important.
- Sample Questions:
- How important is independence and the ability to feed, walk, and otherwise care for yourself?
- How important is it to have your personal preferences for social, cultural, and health needs met?
- How important is it for you to be able to recognize or respond to your loved ones?

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Notes