Updates on Advance Care Planning in Indiana

Susan Hickman, PhD
Professor, Indiana University
Director, IU Center for Aging Research, Regenstrief Institute
Director, Indiana Patient Preferences Coalition

INDIANA UNIVERSITY

50 years Regenstrief Institute

What is Advance Care Planning?

- Part of a continuum of care planning
- Prepares patients and surrogates for communication and medical decision-making
- Tailored in-the-moment and advanced decisions at every life stage

Factors that shape advance are planning

- What does quality of life mean to the person?
- Personal factors
  - Readiness
  - Decision-control preferences
  - Prognostic awareness
  - Trade-offs
- Friend/family/community social norms and support
- Legal considerations

2013
Indiana POST Act

2018
POST Updates
Proxy Hierarchy

2021
Advance Directives
Overhaul Bill

2023
Proxies, POST, and the Out-of-Hospital DNR

Indiana General Assembly

Indiana Advance Directives Statutory Overhaul - 2021

- Conflicting statutes
- Outdated language
  - 29 years old!
- Multiple methods to appoint a legal representative
- Unclear decision standards for legal representatives
- Inhibiting innovation and progress

New Definitions for Common Terms

- Advance directives
- Presence
- Observe
- Remote
- Incapacity
- Best interest
- Reasonably available

Advance Directive

- Advance Directive Components:
  - Name 1 or more health care representatives (HCRs)
  - State specific health care decisions and/or treatment preferences, including preferences for life-prolonging procedures or palliative care
- No official or mandatory form or language for the AD

Indiana Declarations – Mandatory Language

Indiana Living Will

If at any time my hysician cert iting that: (1) I have an incurab , or illness; (ath will occur within a short t d (of life prolo rocedures would serve or tificia the dyin ss, I direct that such proc be withh hdrawn hat I be permitted to d ally with o rfor or provision of any medical pro or medicatio ovide me with comfort care or t te pain, and, icated below, the provision of ar plied nut ydration.

Indiana Life-Prolonging Proce laration

I, _____ h t eighteen (18 d and of sound mind, w tarily make k y desire that if at any t ave ble injury, d or illness determined t ermina , I reque se of life-prolongin dures tha tend . This includes appro utrition and administration ation, and th of all other medical pro ecessary to *life, to provide comfort care*, absence of my ability to give direct se of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full importance of this declaration.

Signing a new Advance Directive

- Sign before
  - Notary OR
  - Two witnesses

- One witness can be a spouse or relative

INDIANA ADVANCE DIRECTIVE

INDIANA HEALTH CARE REPRESENTATIVE:
A Health Care Representative is a person chosen by you to make healthcare decisions, including end-of-life decisions, if you are unable to make your own. It is a good idea to talk with this person about your preferences ahead of time. A doctor will determine if you are unable to make your own decisions.

My name (Full Legal Name – also known as "declarant") Date of Birth (MM/DD/YYYY)

_____ _____

My Health Care Representative can make decisions for me if I cannot make and share my own health care decisions. My Health Care Representative must follow my wishes and values. My values include my ideas about dignity and quality of life. If my Health Care Representative does not know my wishes, my Health Care Representative must act in good faith and make decisions in my best interests. These decisions include but are not limited to:

- Agreeing to medical treatment
- Stopping medical treatment
- Refusing medical treatment
- Arranging comfort care

I want the following person to be my Health Care Representative (HCR):

HCR Name HCR Phone Number

_____ _____

If my primary HCR named above is not able or available to act for me, I want the following person to be my backup Health Care Representative:

Backup HCR Name Backup HCR Phone Number

_____ _____

OPTIONAL STATEMENT OF PREFERENCES:
I would like to provide some additional guidance for my Health Care Representative on my end of life preferences. (Please select only one option below).

☐ The ***quality of my life*** is more important than the length of my life. If I am unable to make my own decisions and my attending physician believes that I will not recover, I do not want treatments to prolong my life or delay my death. Instead, I would want treatment or care to make me comfortable and to relieve me of pain.

☐ ***Staying alive*** is more important to me, no matter how sick I am or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible, in accordance with reasonable medical standards.

☐ I choose to NOT complete this section at this time.

Declarant Name: _____

REQUIRED SIGNATURES:
By signing this form, I cancel and revoke every health care power of attorney I signed in the past.

_____ _____
Signature (Declarant) Date

_____
Printed Name (Declarant)

This form must be either signed by 2 adult witnesses (below left) or notarized (below right) to be legally valid.

SIGNATURE OF 2 ADULT WITNESSES

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

_____
Signature of Adult Witness 1

_____
Printed Name of Adult Witness 1

_____
Date

_____
Signature of Adult Witness 2

_____
Printed Name of Adult Witness 2

_____
Date

_____ Initial here if the Witnesses participated by phone.

This advance directive was created by the Indiana Patient Preferences Coalition and is freely available. See www.INadvancedirectives.org for more information.

NOTARIZATION

STATE OF INDIANA)
) SS:
COUNTY OF _____)

Before me, a Notary Public, personally appeared _____ [*name of signing Declarant*], who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witness my hand and Notarial Seal on this _____ day of _____, 20____.

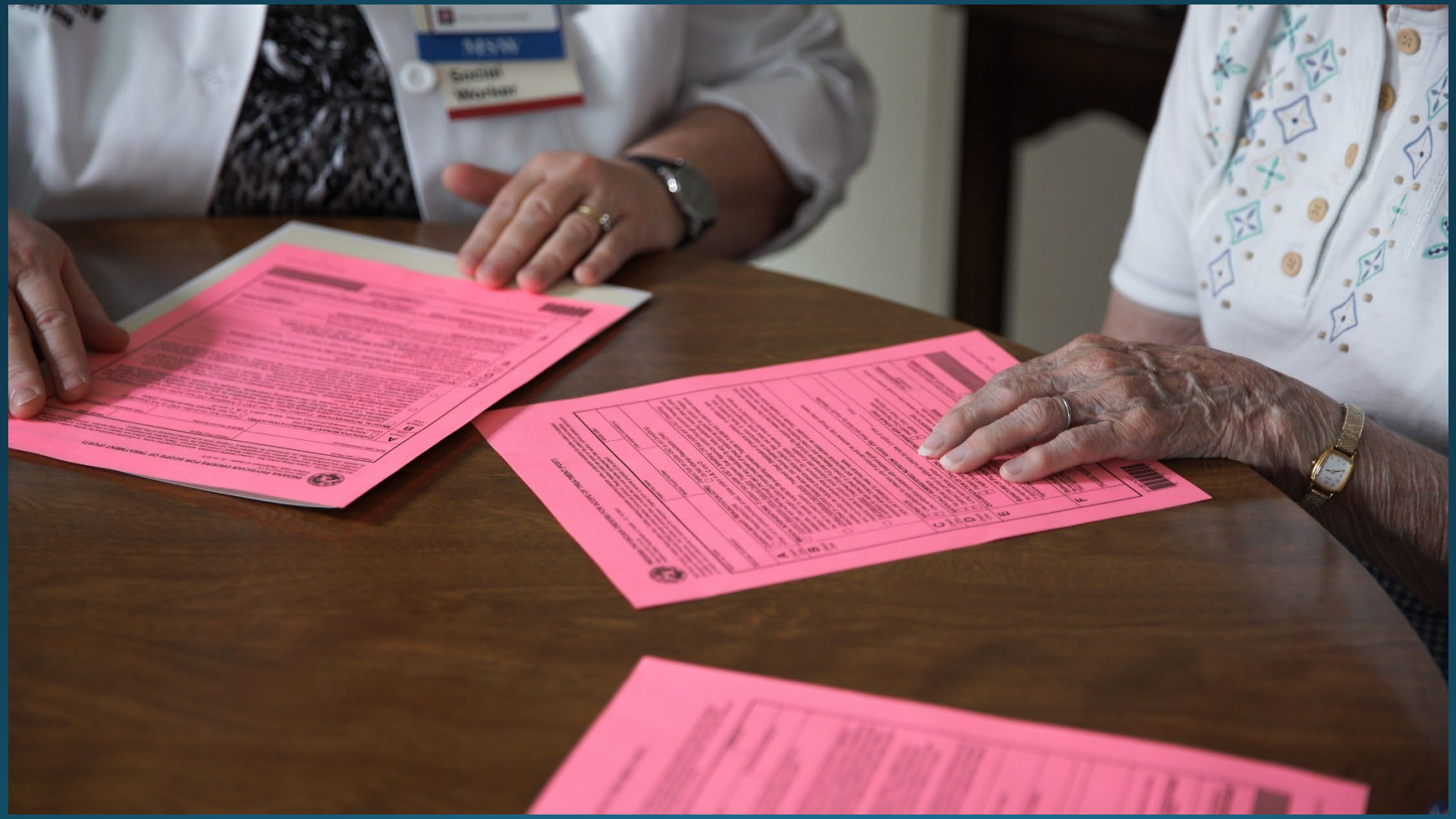
_____
Signature of Notary Public

_____
Notary's Printed Name *(if not on seal)*

_____
Commission Number *(if not on seal)*

_____
Commission Expires *(if not on seal)*

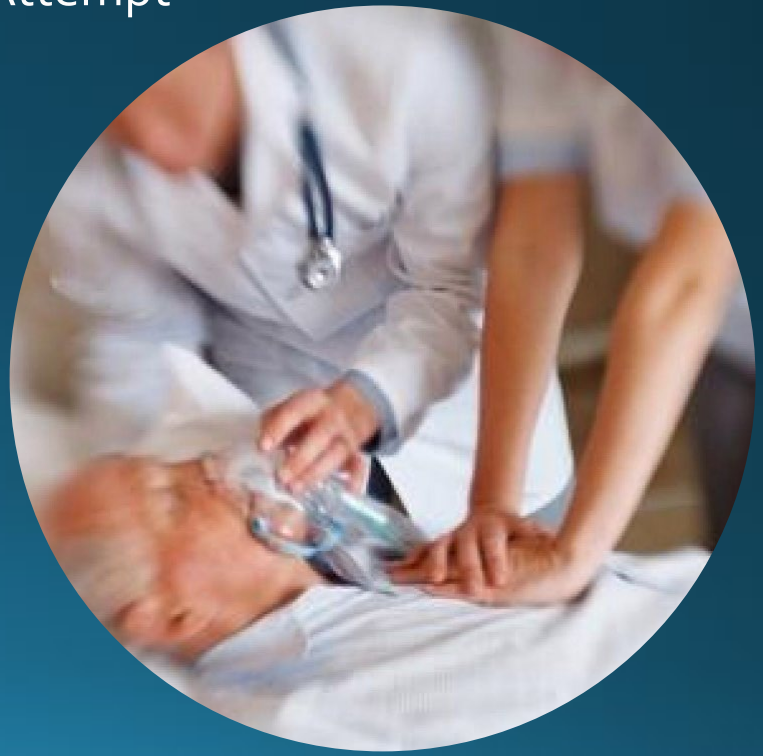
_____
Notary's County of Residence



The role of documentation

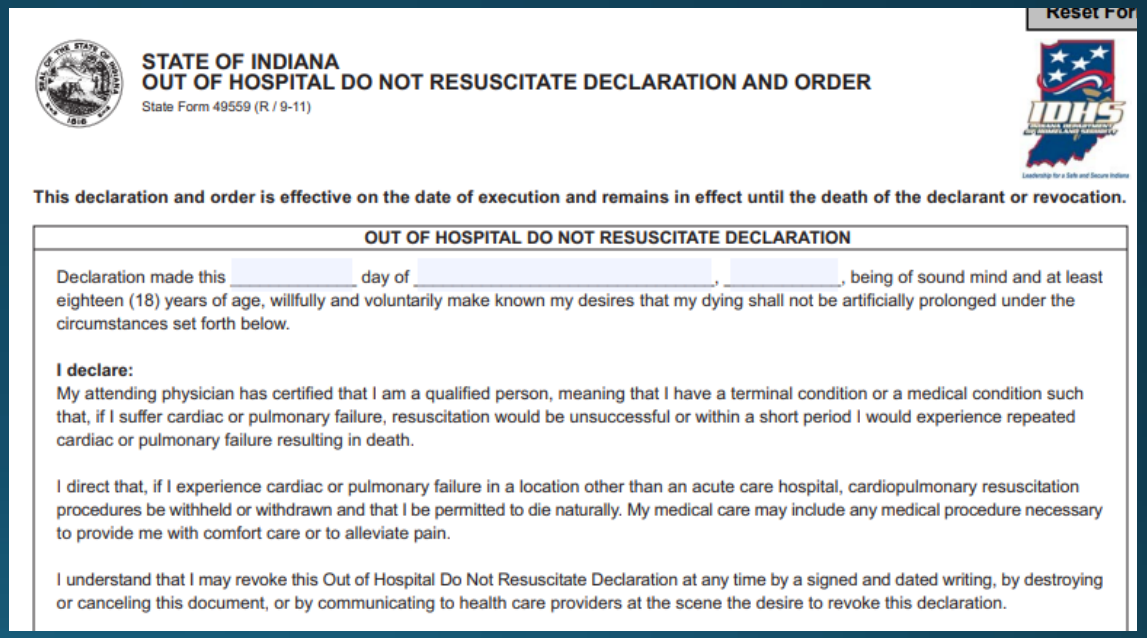
Medical Orders

- Code status orders
  - Routine in hospitals and nursing facilities
  - Do Not Resuscitate/Do Not Attempt Resuscitation or Full Code/Attempt Resuscitation
- Do Not Hospitalize orders
  - Less common
- POLST/POST/MOST/MOLST



OHDNR order form

- Advanced practice registered nurses (APRNs) and Physician Assistant's may sign OHDNR
- Proxy or health care rep can be declarant (new!)
- Form has not been updated



Reset For

STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER
State Form 49559 (R / 9-11)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this _____ day of _____, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

I declare:
My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

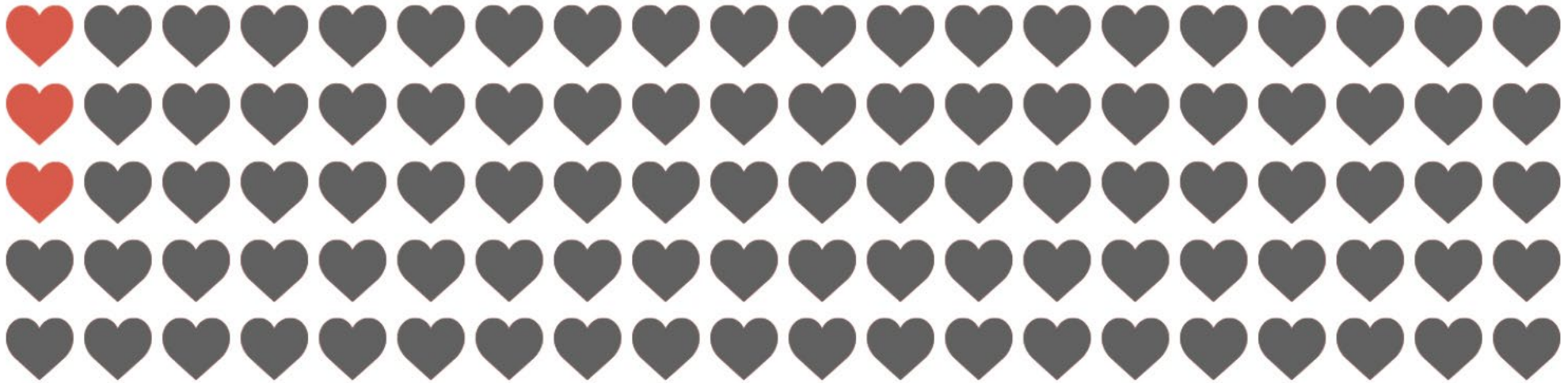
I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

Limitations of Code Status

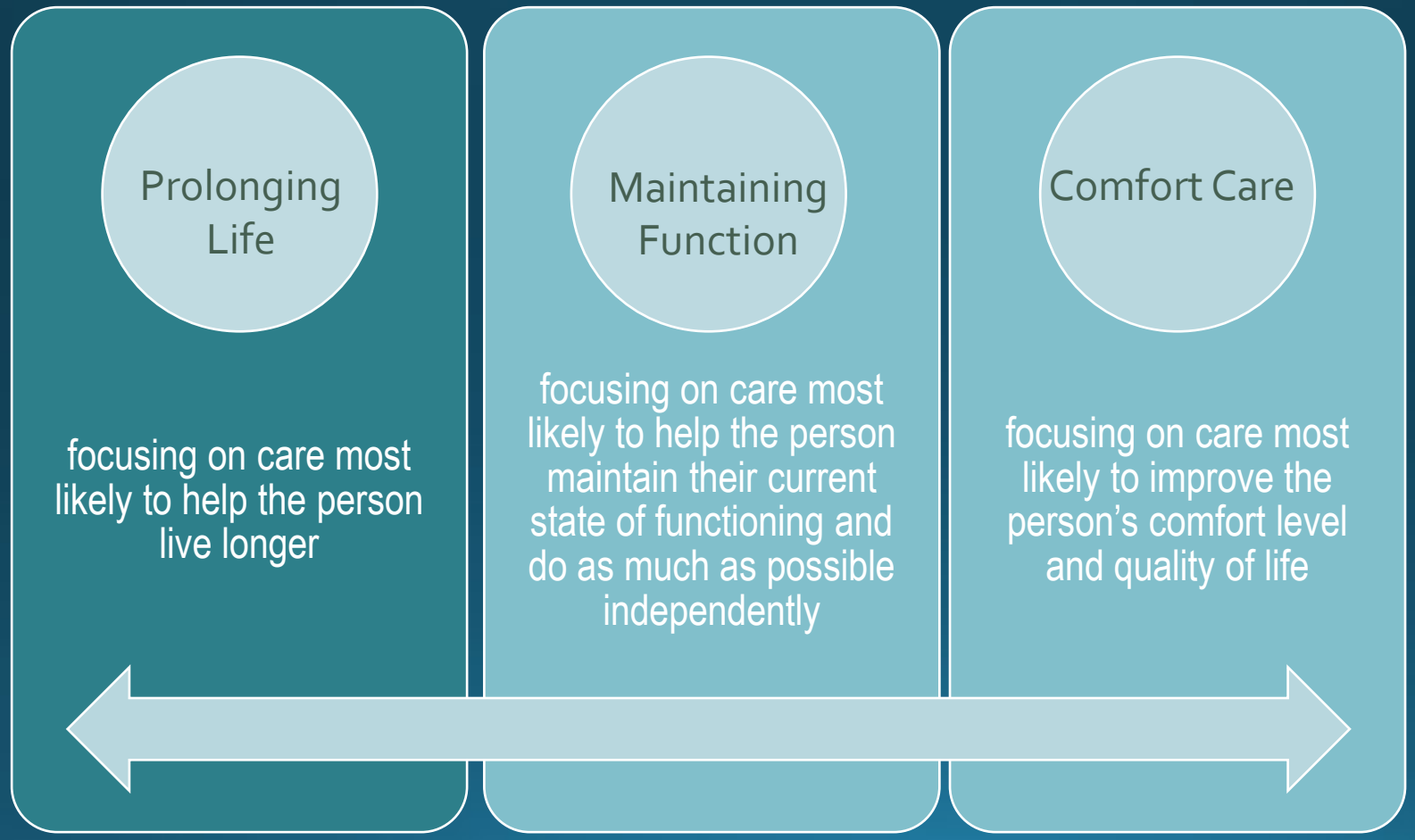
- Addresses resuscitation only
- Simplification
- Over-generalized to reflect preferences for other treatments

DNR ≠ Do Not Treat

CPR IN THE NURSING HOME



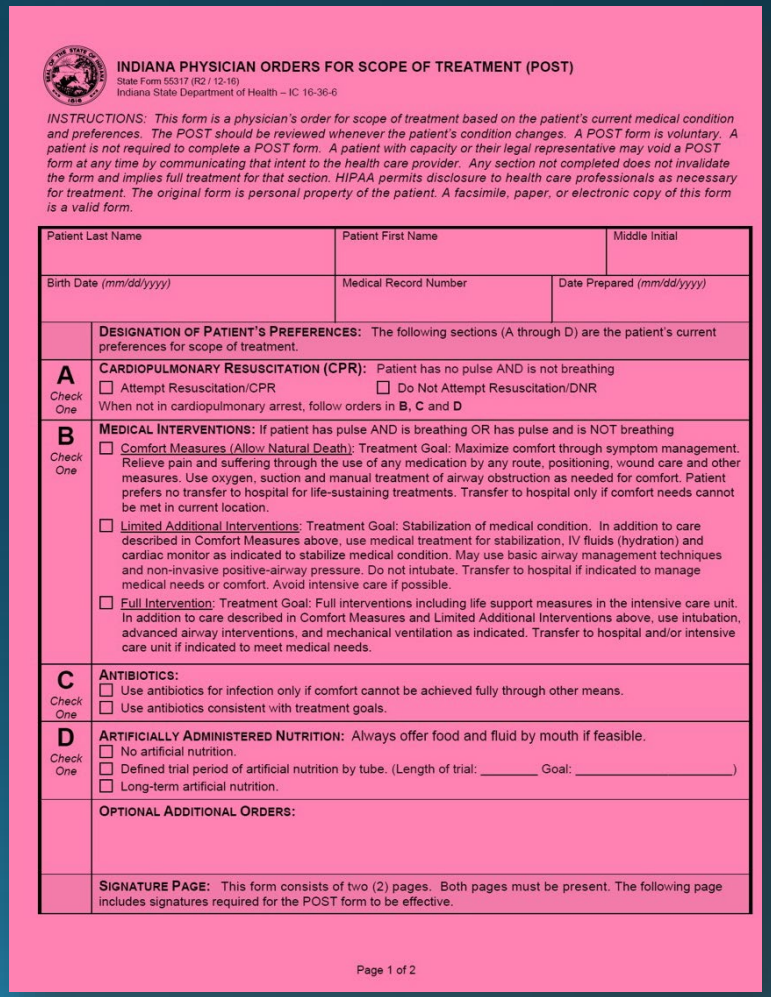
Identifying Goals of Care



POLST: Portable Medical Orders

- POLST: Portable Medical Orders
  - Also known as POST, MOST, MOLST, etc.
- Documents preferences as actional medical
- Signed by clinician
- Valid throughout the healthcare setting
- Transfers across treatment settings

www.polst.org



INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)
State Form 55317 (R2 / 12-16)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment based on the patient's current medical condition and preferences. The POST should be reviewed whenever the patient's condition changes. A POST form is voluntary. A patient is not required to complete a POST form. A patient with capacity or their legal representative may void a POST form at any time by communicating that intent to the health care provider. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name	Patient First Name	Middle Initial
Birth Date *(mm/dd/yyyy)*	Medical Record Number	Date Prepared *(mm/dd/yyyy)*

DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.

A *Check One*
CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing
☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNR
When not in cardiopulmonary arrest, follow orders in **B, C** and **D**

B *Check One*
MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing
☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.
☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.
☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

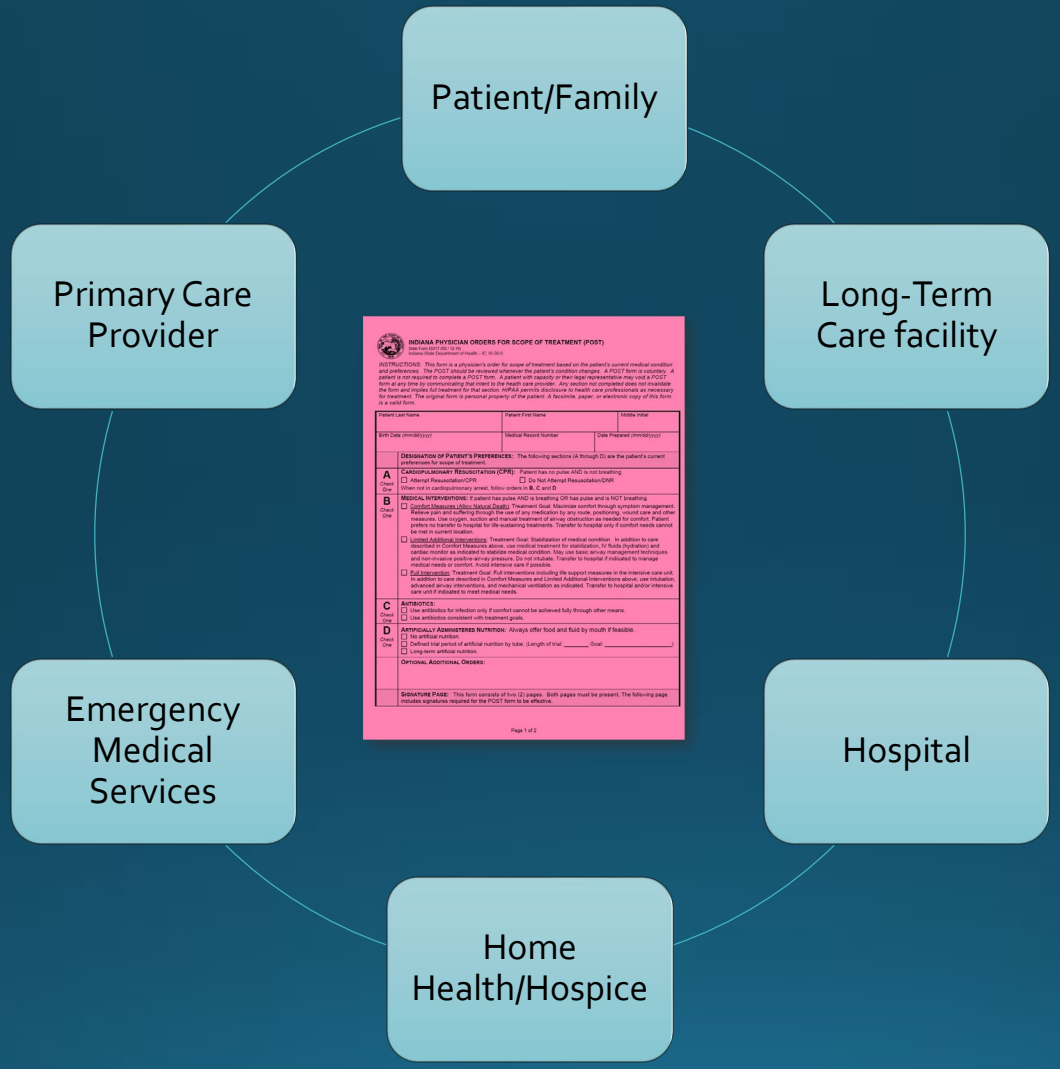
C *Check One*
ANTIBIOTICS:
☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.
☐ Use antibiotics consistent with treatment goals.

D *Check One*
ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.
☐ No artificial nutrition.
☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)
☐ Long-term artificial nutrition.

OPTIONAL ADDITIONAL ORDERS:

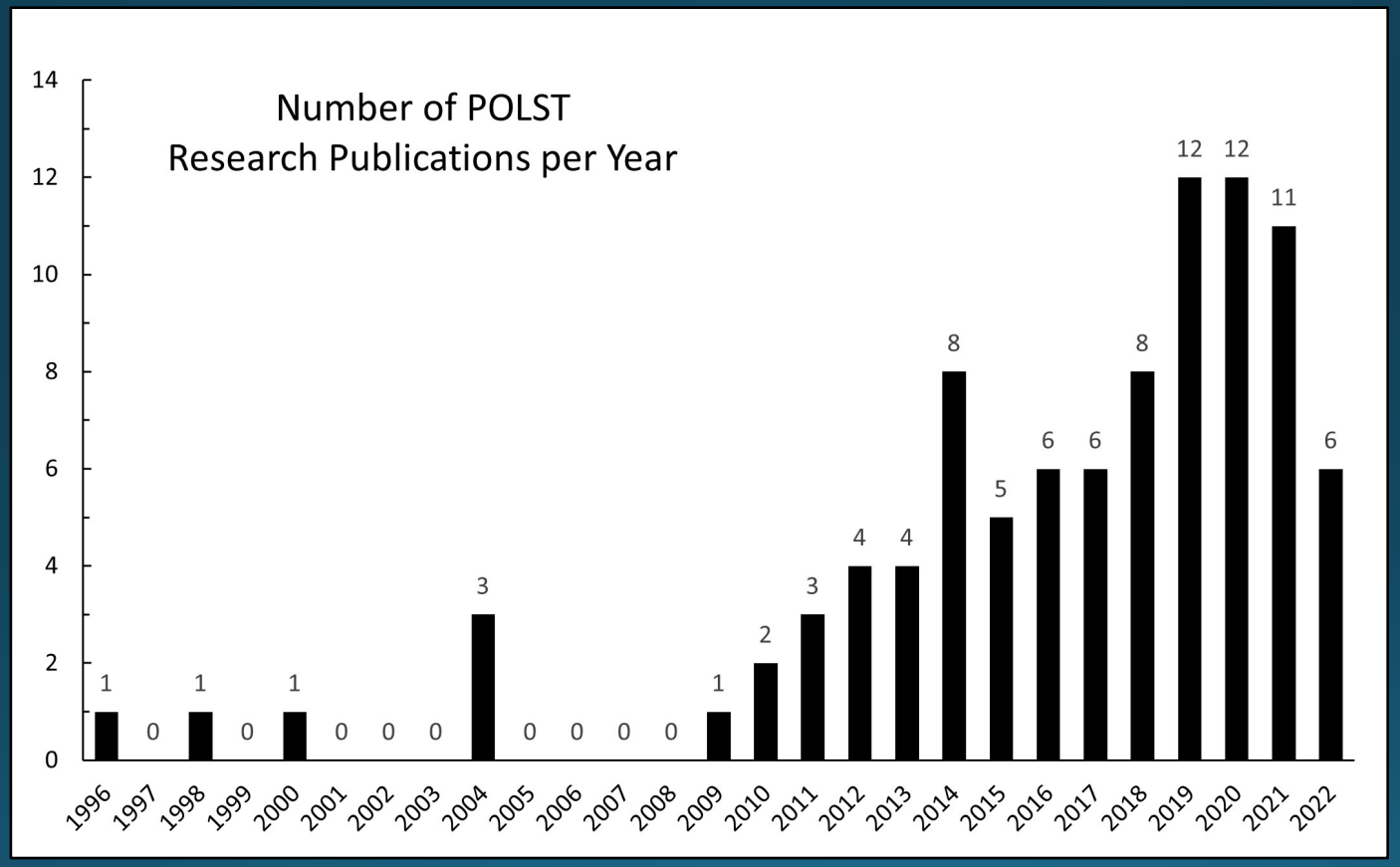
SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

Page 1 of 2



POLST as a Communication Tool

What is the evidence for POLST?



What is the evidence for POLST?

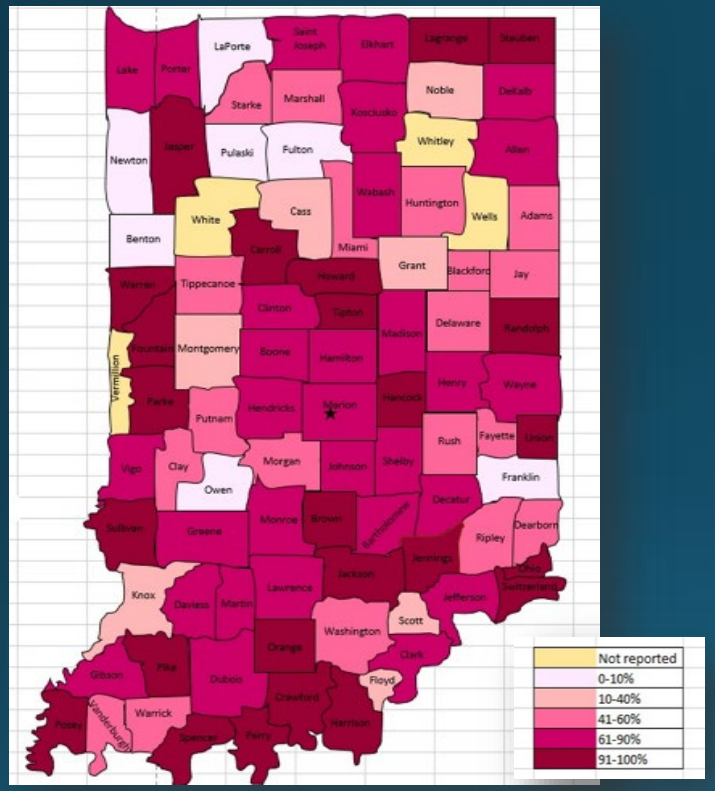
POLST use is significantly associated with key ACP outcome domains including:

- ***Quality of Care***
- ***Action***
- ***Healthcare Utilization***

Outcome Assessed	Outcome Example	Outcomes #	Sig. Associations No. (%)
Quality of Care	Concordance, Satisfaction	19	15 (79%)
Action	Communication, Documentation	12	9 (75%)
Healthcare Utilization	Expenditures, Palliative Care	35	16 (46%)
Process	Behavior Change, Perceptions	0	0
Health Status	Quality of Life	4	0 (0%)
Total		**70**	**40 (57%)**

Umberfield et al., JAMDA, 2024

POST in Indiana



CLINICAL INVESTIGATION

Use of the Physician Orders for Scope of Treatment Program in Indiana Nursing Homes

Susan E. Hickman, PhD,[*†] *Rebecca L. Sudore, MD,*[‡] *Greg A. Sachs, MD,*[†§¶] *Alexia M. Torke, MD,*[†§¶] *Anne L. Myers, MPH,*[*] *Qing Tang, MS,*[‖**] *Giorgos Bakoyannis, PhD,*[‖**] *and Bernard J. Hammes, PhD*[††]

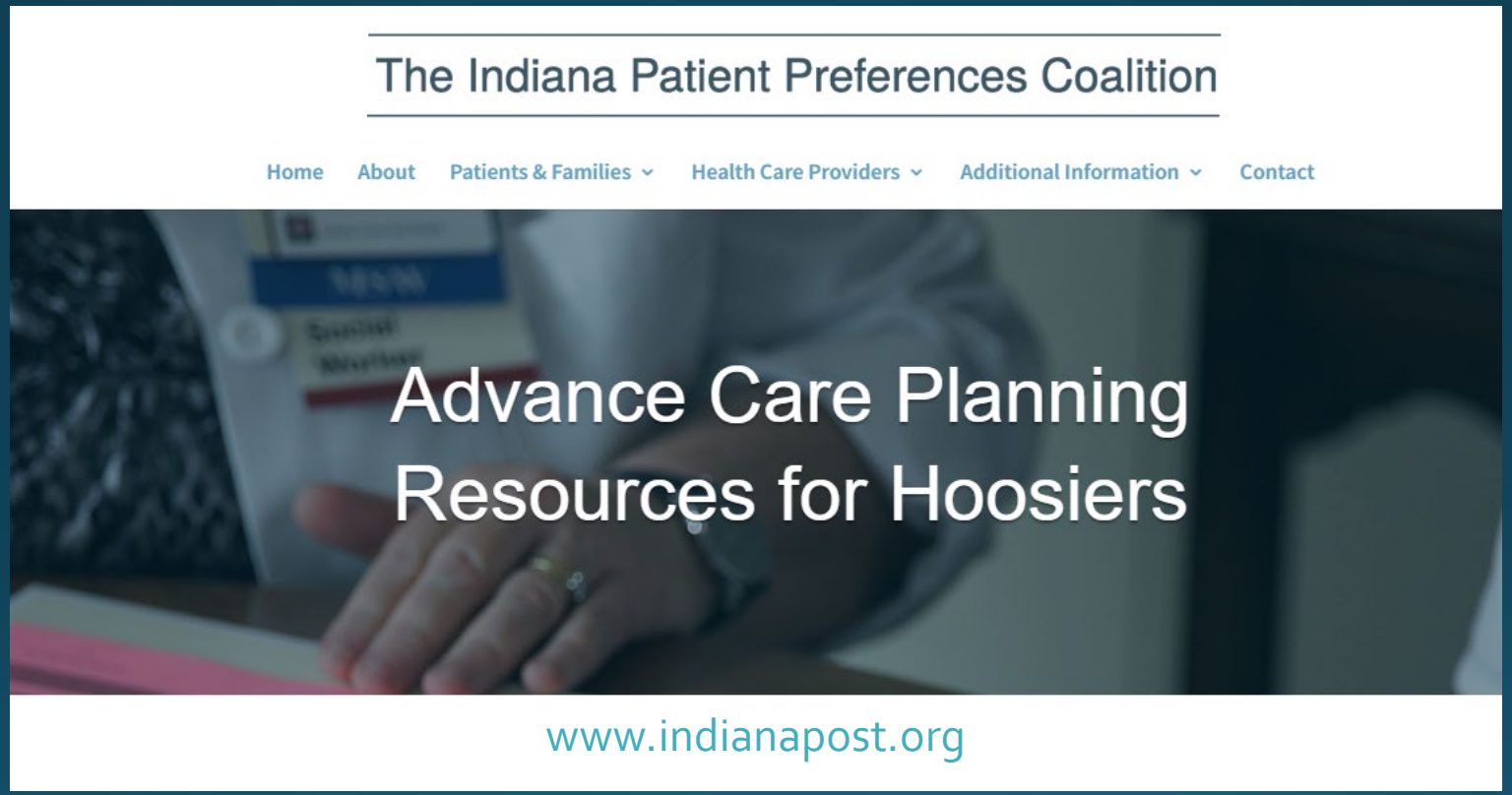
OBJECTIVES: To assess the use of the Indiana Physician Orders for Scope of Treatment (POST) form to record nursing home (NH) resident treatment preferences and associated practices.

majority of NHs were using POST to support resident care. Areas for improvement include creating policies on POST for all NHs, training staff on POST conversations, and considering processes that may enhance the POST conversation, such as finding an optimal time to engage in conversations about

NATIONAL INSTITUTE OF NURSING RESEARCH

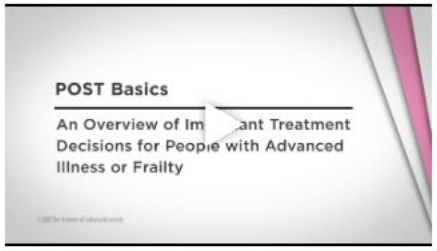
R01NR015255

In 2016, 65% of Indiana nursing homes complete POST after admission



www.indianapost.org

Online Resources



Documents & Resources

POST Guidance for Health Care Professionals
This guidance book provides information to health care providers about how to use the Indiana POST program.

The New Indiana POST Program
An October 2013 video of lecture about the Indiana POST Program featuring Susan Hickman, PhD.

Out-of-Hospital DNR Order Form (English)
As of July 1, 2021, the Indiana Out-of-Hospital DNR Order form can be signed by a physician, advanced practice registered nurse, or physician assistant.

Out-of-Hospital DNR Order Form (Spanish)
This translation of the Indiana Out-of-Hospital Do Not Resuscitate order is provided for educational purposes only. An English version must be signed.

POST Fact Sheet
This cover sheet is designed to accompany the POST form and provides introductory information for patients and families.

POST Revocation Checklist
A checklist outlining the steps required to revoke the Indiana POST.

Indiana Department of Homeland Security POST Information
An educational website containing information about the Indiana POST Program for emergency

Indiana POST and Advance Directives for EMS
An educational packet for EMS developed by the Indiana Fire Chiefs Association EMS Section and the IPPC with the approval of the

Indiana POST Form
The Indiana POST Program is an advance care planning tool that helps ensure treatment preferences are honored.

All Translated POST Forms
Here you can choose from several languages to download translated versions of the POST form.

Using the POST Form

- Original POST is property of patient
  - Bright pink is recommended, but colored paper not required
  - Photocopies or faxed copies are valid
  - Copy should be kept in medical record
  - Send original POST with the patient at time of discharge
- Use is voluntary
  - Document and honor refusals
- Re-evaluate when condition changes

Honoring POST

- You are required to comply with POST unless believe in good faith that:
  - POST is not validly completed;
  - POST has been revoked or there is a request for alternative treatment;
  - It would be medically inappropriate to provide the intervention on the POST;
  - Provider's religious or moral beliefs that conflict with the POST
    - Must attempt transfer to another health care provider if this is the case
- Health care providers are not subject to civil or criminal liability for good faith compliance with or reliance upon POST forms.

Identified elements required to be valid

INSTRUCTIO… …ion about the pat… …to complete a P… …sk the health care p… …ative or proxy (if there… …rovider to void POST… …e professionals… …aper, or electronic copy of this form is a valid form.

Patient Last Name (required)	Patient First Name (required)	Middle Initial
Birth Date *(mm/dd/yyyy)*	Medical Record Number	Date Prepared *(mm/dd/yyyy)*

DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing. (required)

☐ Attempt Resuscitation / CPR ☐ Do Not Attempt Resuscitation / DNR

When not in cardiopulmonary arrest, follow orders in B, C and D.

B *Check One*

MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing.

☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*

ANTIBIOTICS:

☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

☐ Use antibiotics consistent with treatment goals.

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.

☐ No artificial nutrition.

☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition.

OPTIONAL ADDITIONAL ORDERS:

SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

SIGNATURE OF PATIENT, LEGAL REPRESENTATIVE, OR PROXY: In order for the POST form to be effective, the patient, legal representative, or proxy must sign and date the form below.

E

SIGNATURE OF PATIENT, LEGAL REPRESENTATIVE, OR PROXY

My signature below indicates that the physician, advanced practice registered nurse, or physician assistant (or their designee) discussed with me the above orders and the selected orders correctly represent the decisions made during this discussion.

Signature *(required)*	Print Name *(required)*	Date *(mm/dd/yyyy)* *(required)*

F

CONTACT INFORMATION FOR LEGAL REPRESENTATIVE OR PROXY IN SECTION E *(IF APPLICABLE)*: If the signature above is other than patient's, add contact information for the representative or proxy.

Relationship of representative or proxy identified in Section E if patient does not have capacity	Address *(number and street, city, state, and ZIP code)*	Telephone Number

PHYSICIAN ORDER:

A POST form may be executed only by an individual's treating physician, advanced practice registered nurse, or physician assistant, and only if:

(1) the treating physician, advanced practice registered nurse, or physician assistant has determined that:

(A) the individual is a qualified person; and

(B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and

(2) the qualified person, representative, or proxy has signed and dated the POST form

A qualified person is an individual who has at least one (1) of the following:

(1) An advanced chronic progressive illness.

(2) An advanced chronic progressive frailty.

(3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:

(A) there can be no recovery; and

(B) death will occur from the condition within a short period without the provision of life prolonging procedures.

(4) A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

G

DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:

☐ Patient (patient has capacity) ☐ Health Care Representative ☐ Legal Guardian

☐ Parent of Minor ☐ Health Care Power of Attorney ☐ Proxy

H

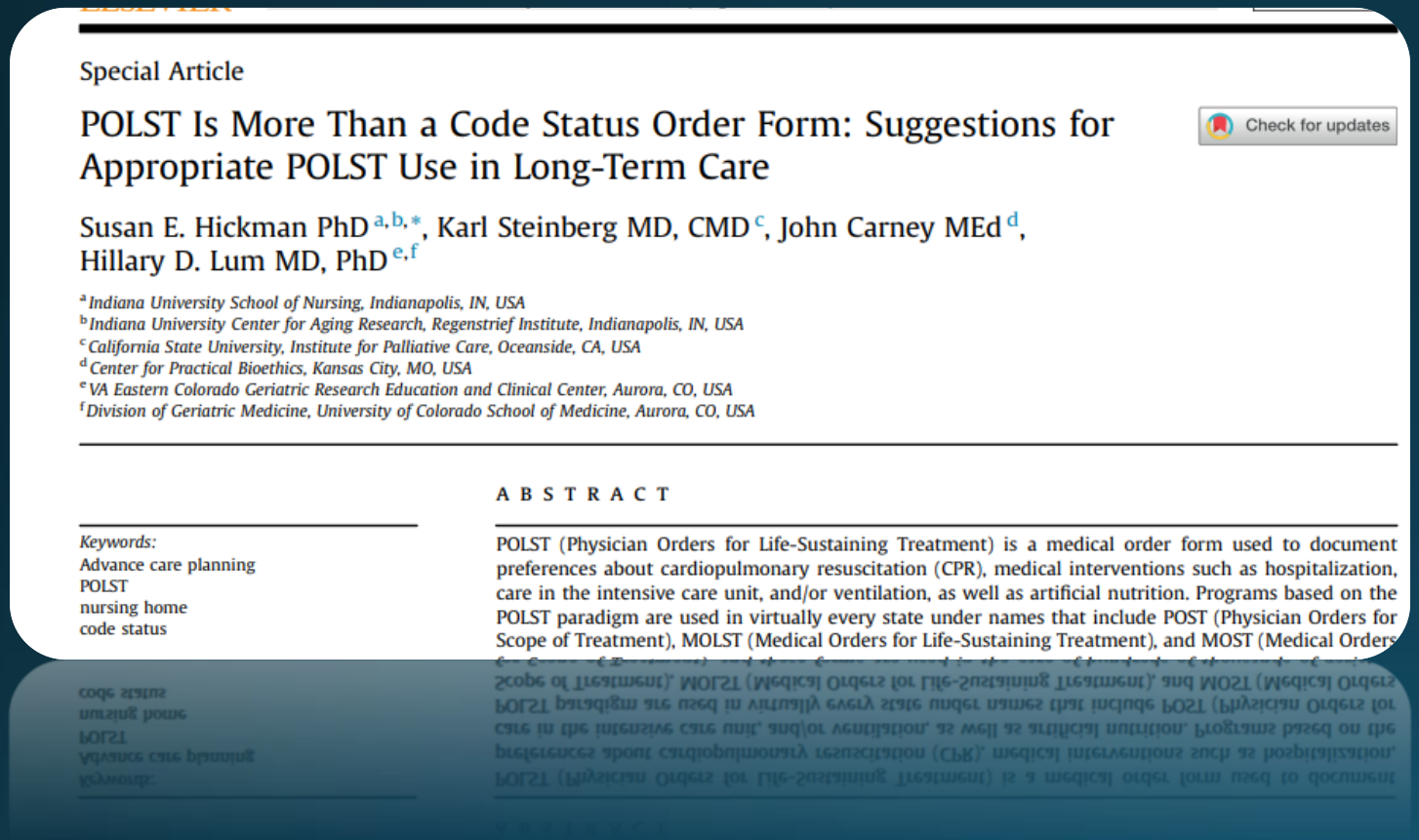
SIGNATURE OF TREATING PHYSICIAN / ADVANCED PRACTICE REGISTERED NURSE / PHYSICIAN ASSISTANT

My signature below indicates that I or my designee have discussed with the patient, patient's representative, or proxy the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Signature of Treating Physician / APRN / PA *(required)*	Print Treating Physician / APRN / PA Name *(required)*	Date *(mm/dd/yyyy)* *(required)*
Physician / APRN / PA office telephone number	Physician / APRN / PA License Number	Health Care Professional preparing form if other than the physician / APRN / PA

I

APPOINTMENT OF HEALTH CARE REPRESENTATIVE: As a patient you have the option to appoint a representative to serve as your health care representative pursuant to IC 16-36-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found on the IDOH web site at https://www.in.gov/health/cshcr/indiana-health-care-quality-resource-center/advance-directives-resource-center/ .



Special Article

POLST Is More Than a Code Status Order Form: Suggestions for Appropriate POLST Use in Long-Term Care

Susan E. Hickman PhD [a,b,*], Karl Steinberg MD, CMD [c], John Carney MEd [d], Hillary D. Lum MD, PhD [e,f]

[a] Indiana University School of Nursing, Indianapolis, IN, USA
[b] Indiana University Center for Aging Research, Regenstrief Institute, Indianapolis, IN, USA
[c] California State University, Institute for Palliative Care, Oceanside, CA, USA
[d] Center for Practical Bioethics, Kansas City, MO, USA
[e] VA Eastern Colorado Geriatric Research Education and Clinical Center, Aurora, CO, USA
[f] Division of Geriatric Medicine, University of Colorado School of Medicine, Aurora, CO, USA

Keywords:
Advance care planning
POLST
nursing home
code status

A B S T R A C T

POLST (Physician Orders for Life-Sustaining Treatment) is a medical order form used to document preferences about cardiopulmonary resuscitation (CPR), medical interventions such as hospitalization, care in the intensive care unit, and/or ventilation, as well as artificial nutrition. Programs based on the POLST paradigm are used in virtually every state under names that include POST (Physician Orders for Scope of Treatment), MOLST (Medical Orders for Life-Sustaining Treatment), and MOST (Medical Orders

What is wrong with using POST as a code status order?

- Use with inappropriate residents
- Unnecessary for individuals who want full code/all interventions
- Never expire
- Must be voluntary
- Increases likelihood of poor quality discussions

Setting the stage for resident-centered care

- Discuss risks, benefits, and alternatives
  - Progressive dementia = terminal illness
  - Decisions about
    - Hospitalization
    - Infection management
    - Feeding difficulties
    - Co-morbid medical condition management

Exploring understanding

- What is understanding of disease and what will happen?
  - Diagnosis, complications, prognosis, available treatments
- What education is needed?

Exploring values

- What gives life meaning?
- How does their illness impact their quality of life?
- What does a good day look like?

Capacity in dementia

- For person living with dementia, ability to engage is dependent on:
  - Stage of illness (Mild, moderate, or severe)
  - Type of decision being made

Assent and Dissent

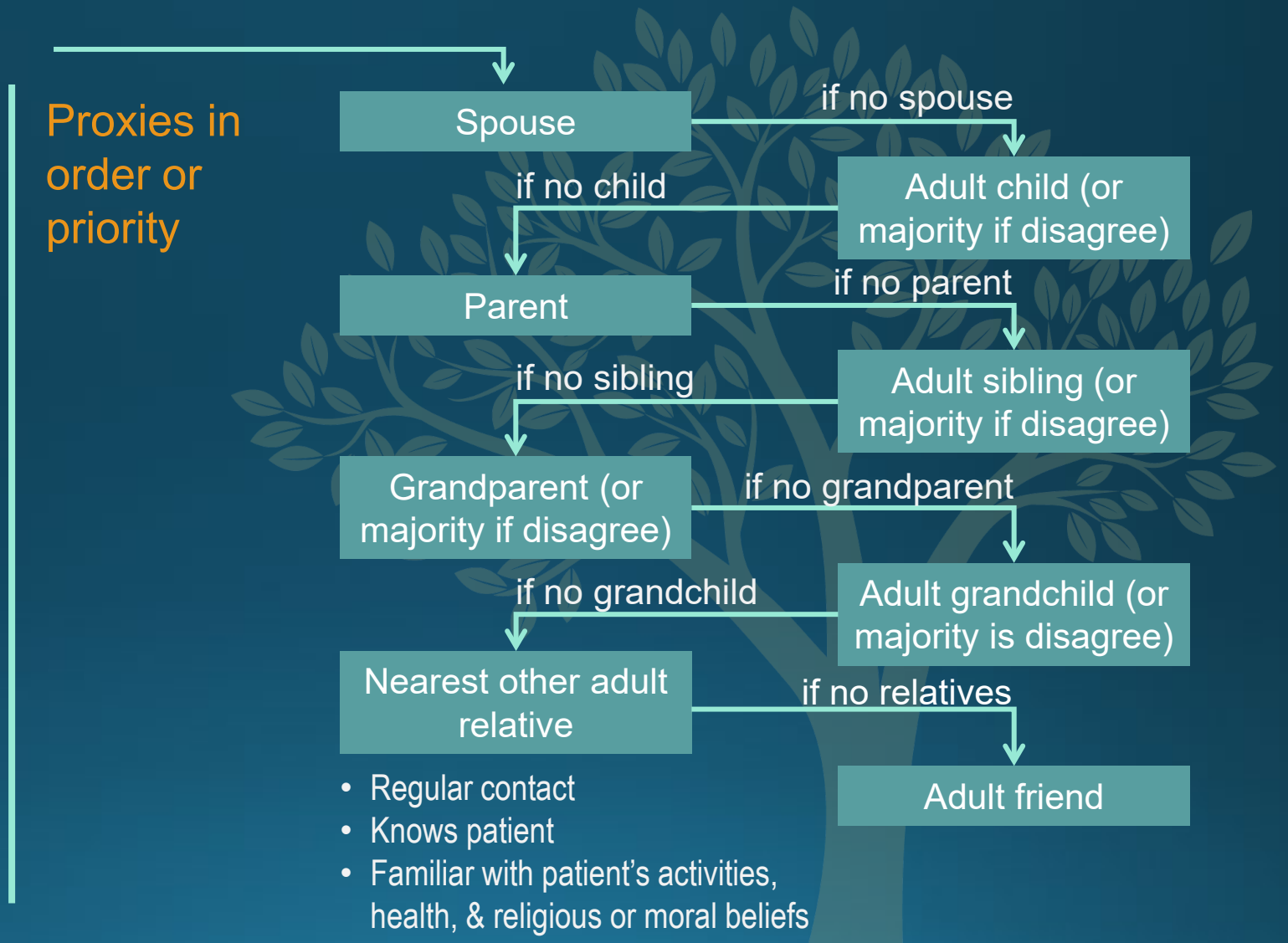
- Preferences of adults who lack capacity expressed
  - Verbally
  - Behaviorally
  - Emotionally
- Ability to make a meaningful choice
- Minimal level of understanding

Who decides if the PLWD cannot decide for self?

- Default surrogate/proxy
- Legally appointment representative/healthcare representative
- Power of attorney **for health care**
- Guardian with health care decision-making authorities

Proxy Hierarchy

A person who can consent to health care on behalf of an individual who does NOT have a valid AD signed and in place



Appointing a health care representative

- Decisional capacity required is lower than for more complex decisions
  - Identify a person
  - Make a consistent choice
  - Understand they will be making heath care decisions

Health Care Representative Responsibilities

- Be "reasonably available"
  - able to be contacted without undue effort; and
  - willing and able to act in a timely manner considering the urgency of that individual's health care needs or health decisions.
- Provides informed consent to healthcare treatment on behalf of the patient if the patient loses decision-making capacity.

HCR Standards of Conduct

- If the patient is unable to independently make healthcare decisions:
  - HCR must always act in good faith
  - Make health care decisions believes patient would have made
  - Decisions must closely align with the patient's express or implied intentions (if known) or in best interest

Ethical decision-making

Decision Making Standards

- Known Preferences
- Substituted Judgement
- Best Interests

Known Preferences

- Living Will
- Stated preferences
- Prior decisions

Substituted Judgement

- Recommended rely on substituted judgement for residents with prior decisional capacity
- Base the decisions that the patient would make if able to do so
- Supports autonomy

Best interests

- Promotion of the individual's welfare, based on consideration of material factors, including:
  - relief of suffering
  - preservation or restoration of function
  - quality of life

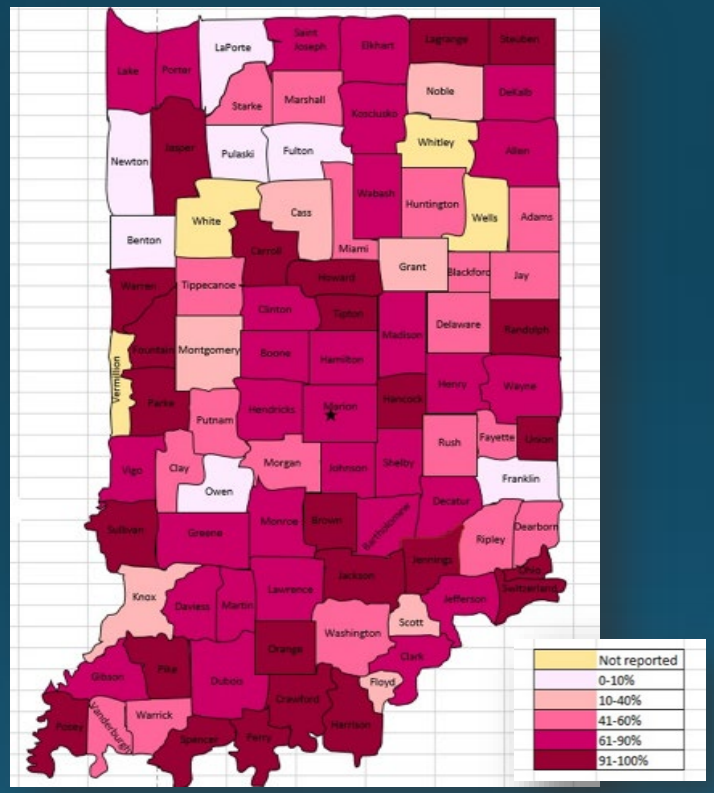
- In collaboration with the health care team

Successful Implementation of ACP

- Increasing recognition of the complexity of doing it well

- Considerations include
  - Training of team – ACP is a team sport!
  - Resources (E.g., forms, facilitation guide, educational materials, space)
  - Protocols and documentation
  - Workflow integration
  - Periodic review

ACP and POST in Indiana



In **2016,** 65% of Indiana nursing homes complete POST after admission.

Is that still true?

We need your help!

We are conducting a brief online survey on ACP (approx. 15 minutes)

Who should answer this survey for my building?

- The person primarily responsible for advance care planning

Participants will receive $10 Starbucks eGift Card upon completion

Link for contact info for your NH

https://redcap.link/nh00jeau

Discussion

Thank you!

www.indianapost.org
www.polst.org
www.INadvancedirectives.org

Questions? Contact me at
Hickman@iu.edu