VCU Palliative Care ECHO*

March 14, 2019

Basics of Advance Care Planning

*ECHO: Extension of Community Healthcare Outcomes

Continuing Medical Education

February 28, 2019 | 12:00 PM | teleECHO Conference

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Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosures

February 28, 2019 | 12:00 PM | teleECHO Conference

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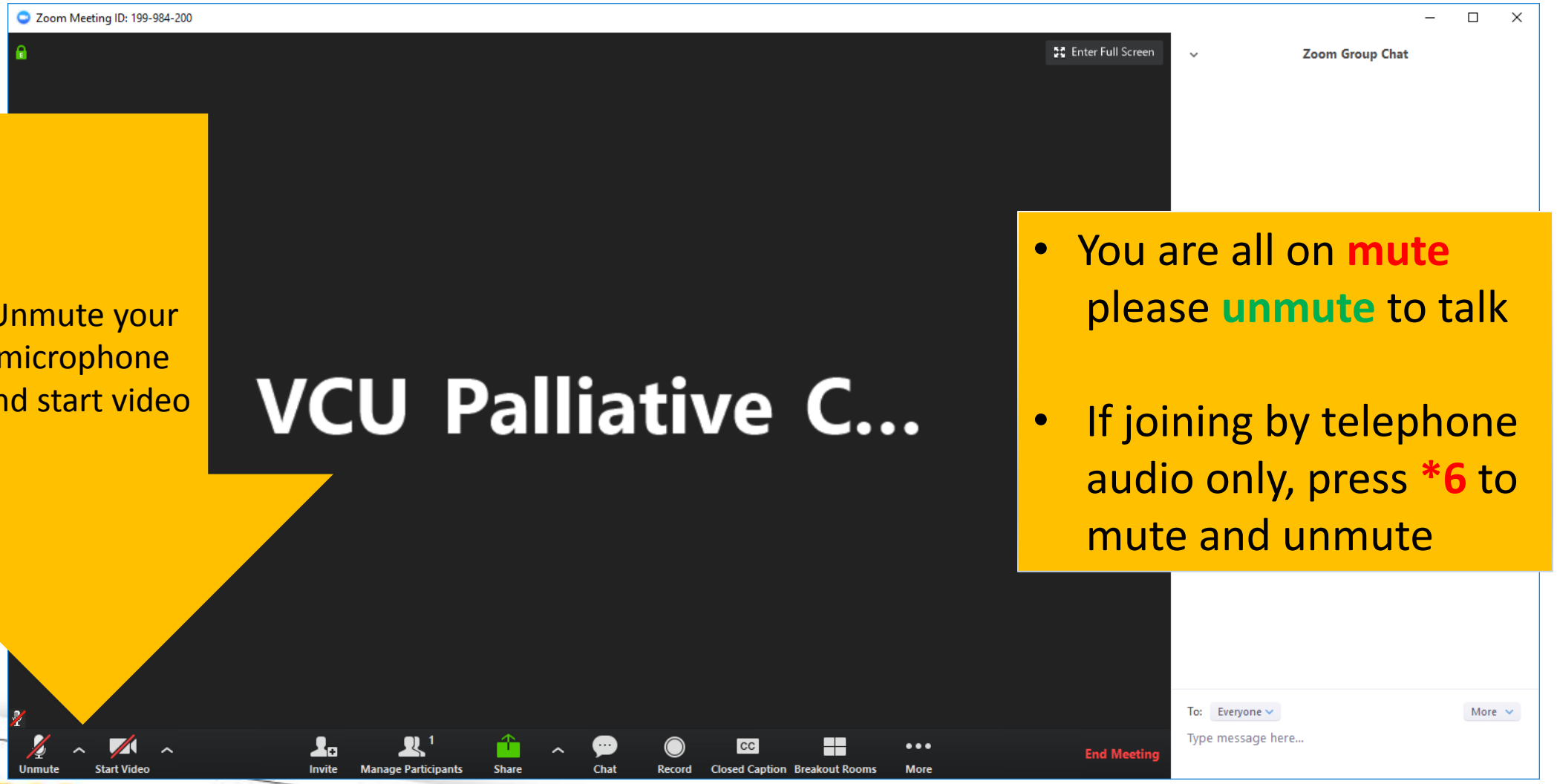
The following Planning Committee and Presenting Faculty Members report having no relevant financial relationships:

Danielle Noreika, MD

Candace Blades, JD, RN

No commercial or in-kind support was provided for this activity

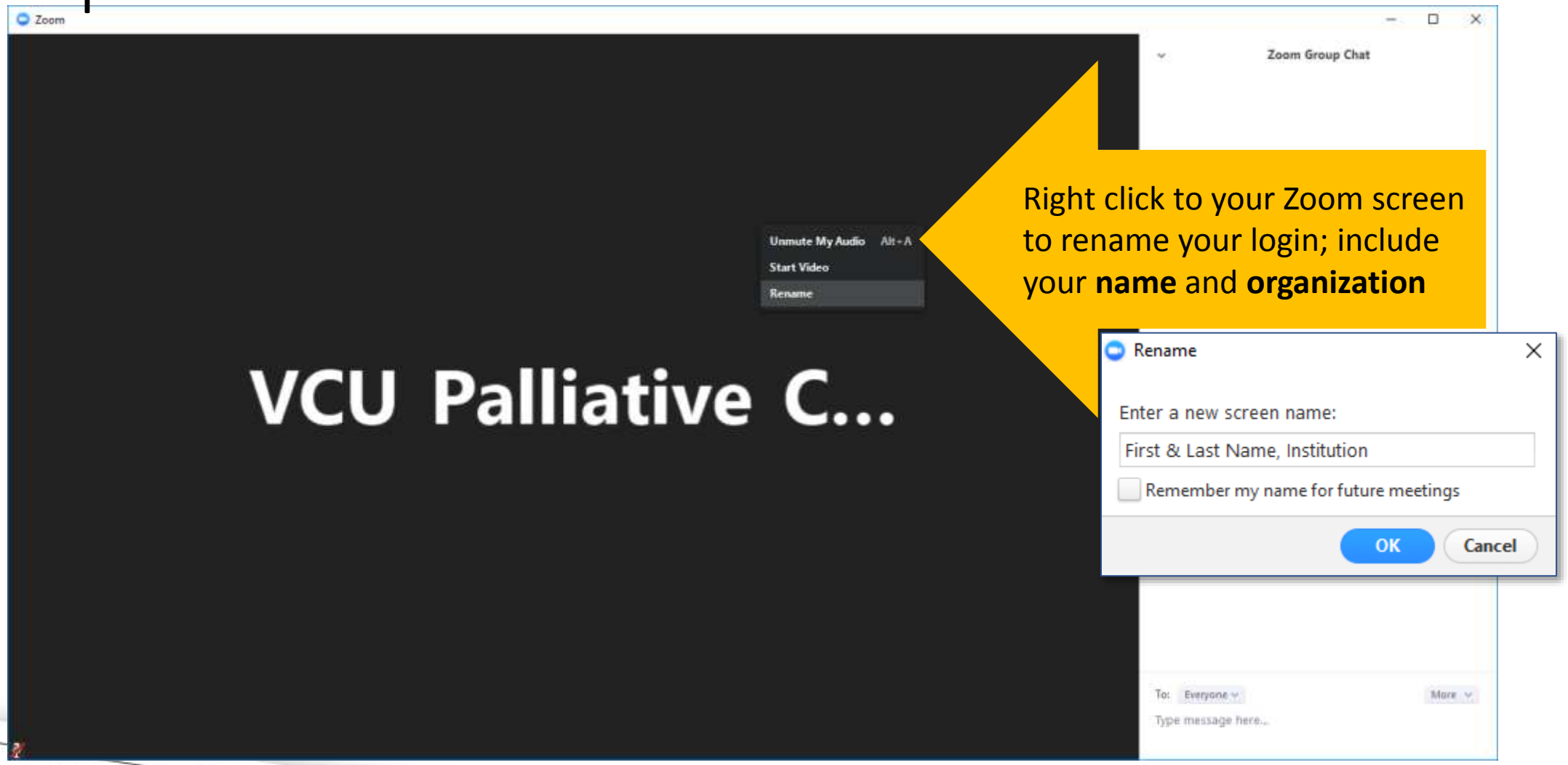
Helpful Reminders



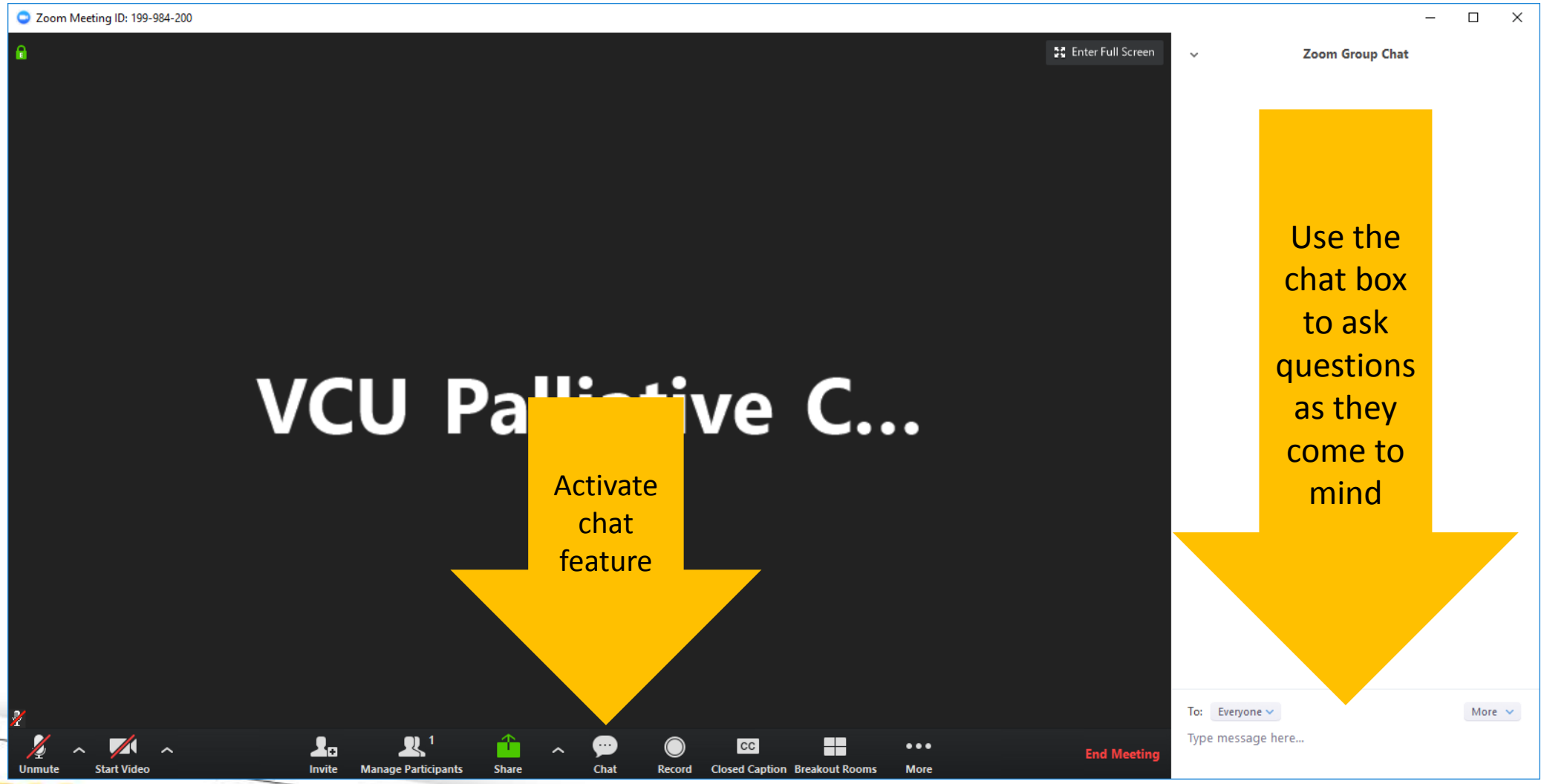
Unmute your microphone and start video

- You are all on **mute** please **unmute** to talk
- If joining by telephone audio only, press ***6** to mute and unmute

Helpful Reminders



Helpful Reminders



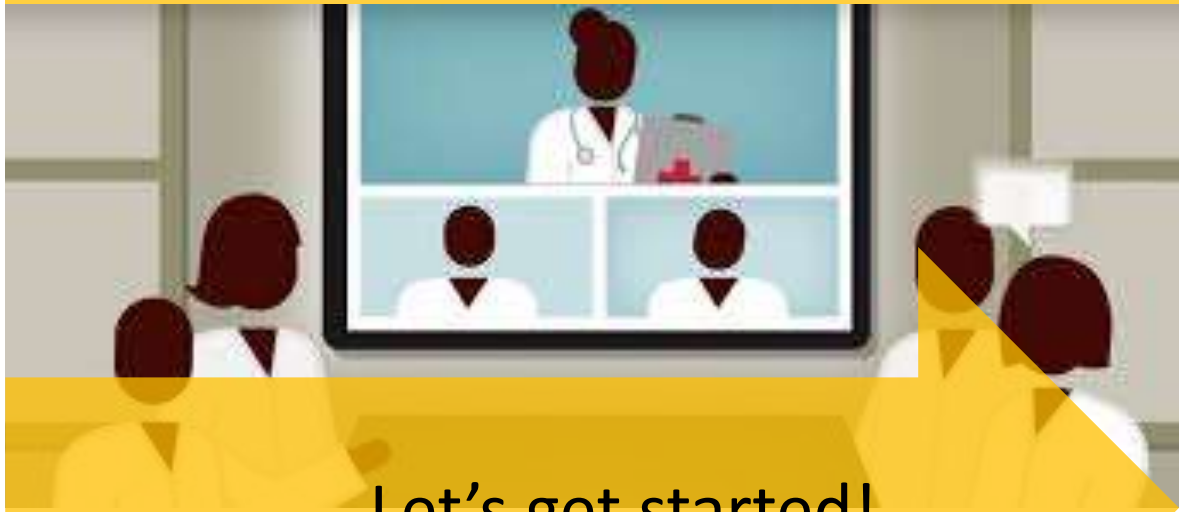
What to Expect

I. Didactic Presentation
   20 minutes + Q&A

II. Case Discussions (x2)
   - Case Presentation
     5 min.
   - Clarifying questions from spokes, then hub
     2 min. each
   - Recommendations from spokes, then hub
     2 min. each
   - Summary (hub)
     5 min.

III. Closing and Questions

- Bi-weekly tele-ECHO sessions (1.5 hours)
- Didactic presentations developed by inter-professional experts in palliative care
- Website: www.vcuhealth.org/pcecho
- Email: pcecho@vcuhealth.org



Let's get started!

Hub Introductions

VCU Team	
Clinical Director	Danielle Noreika, MD, FACP, FAAHPM Medical Director/Fellowship Director VCU Palliative Care
Clinical Experts	Egidio Del Fabbro, MD – VCU Palliative Care Chair Jason Callahan, MDiv – Palliative Care Specialty Certified Tamara Orr, PhD, LCP – Clinical Psychologist Diane Kane, LCSW – Palliative Care Specialty Certified Felicia Hope Barner – RN Candace Blades, JD, RN – Advance Care Planning Coordinator Brian Cassel, PhD – Palliative Care Outcomes Researcher
Support Staff Program Manager Practice Administrator IT Support	 Teri Dulong-Rae / Bhakti Dave, MPH David Collins, MHA Frank Green

Spoke Participant Introductions

Name and Institution

Basics of Advance Care Planning

Candace Blades, JD, RN

March 14, 2019

Objectives

The participant will be able to:

1) Understand the Advance Care Planning (ACP) process
2) Identify the different types of ACP documents and the legal requirements for each type.
3) Become familiar with communication skills to facilitate ACP conversations.

What is Advance Care Planning? (ACP)

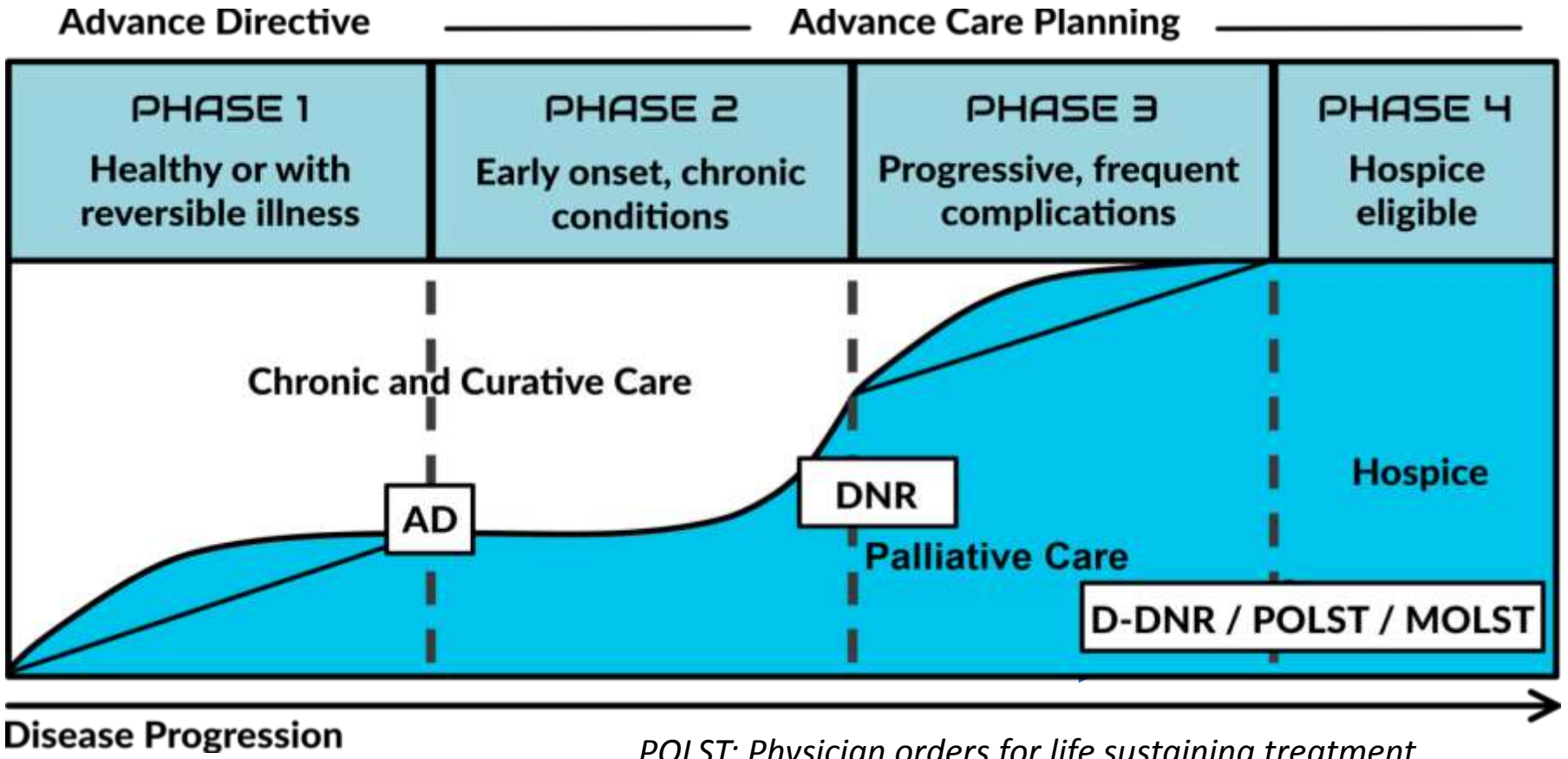
ACP is a process of planning for future medical decisions. To be effective this process includes….

- **Reflection** on goals, values, and beliefs (including cultural, religious, spiritual, and personal)
- **Understanding** possible future situations and decisions
- **Discussion** of these reflections and decisions with those who might need to carry out the plan.

ACP is about thoughtful *conversation* that yields a quality ACP document such as an Advance Directive.

ACP Over Time

Advance Care Planning begins with basic advance care planning/advance directives for healthy adults and continues through the approach to end of life



POLST: Physician orders for life sustaining treatment
(In Virginia: POST—Physician Orders for Scope of Treatment)

Source: AHA CPI Analysis, 2012, with contributions from 2012 CTAC data And 2011 Center to Advance Palliative Care data.

- Enhanced goal-concordant care
- Improved quality of life reduced suffering
- Higher patient satisfaction
- More and earlier hospice care
- Fewer hospitalizations
- Time to make informed decisions and fulfill personal goals

- Better patient and family coping
- Eased burden of decision making for families
- Improved bereavement outcomes
- Less non-beneficial care and costs

Advance Directives

ACP involves communication of important healthcare wishes to family, loved ones and healthcare providers. Advance Directives are legal documents that express those wishes

Living Will/Advance Directive

Healthcare Power of Attorney (Health Care Agent)

DNR and DDNR

POST

Advance directives can be:

- Created by any adult ≥18 years of age or emancipated minors.
- Created by an individual with sufficient mental capacity. Decisional capacity includes the ability to understand the relevant information, the choices and the ability to state a decision. Capacity is task specific. Individuals with mild dementia may understand the issues related to ACP even if they no longer have the ability to live independently, for example. Capacity is presumed but where there are concerns about lack of capacity, a provider should make a determination.
- Cancelled, revoked, or modified at any time, but only by the individual who created the advance directive. A *Healthcare Agent and/or family cannot create, revoke or override a patient's AD.*

Virginia Standard Advance Directive

The standard Virginia Advance Directive:

- Allows for the appointment of a Healthcare Agent
- May contain Living Will instructions about treatment in the event of imminent death or where there is no awareness of self or surroundings or no ability to interact with others and treatment is very unlikely to improve the situation
- Allows for a statement about Anatomical gifts

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, _____, willingly and voluntarily make known
Printed Name of Individual Making This Advance Directive for Health Care (Declarant)
my wishes in the event that I am incapable of making an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II AND III BELOW.)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

A. Appointment of My Agent

I hereby appoint _____
Name of Primary Agent — E-mail Address

_____
Home Address — Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

_____
Name of Successor Agent — E-mail Address

_____
Home Address — Telephone Number

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want

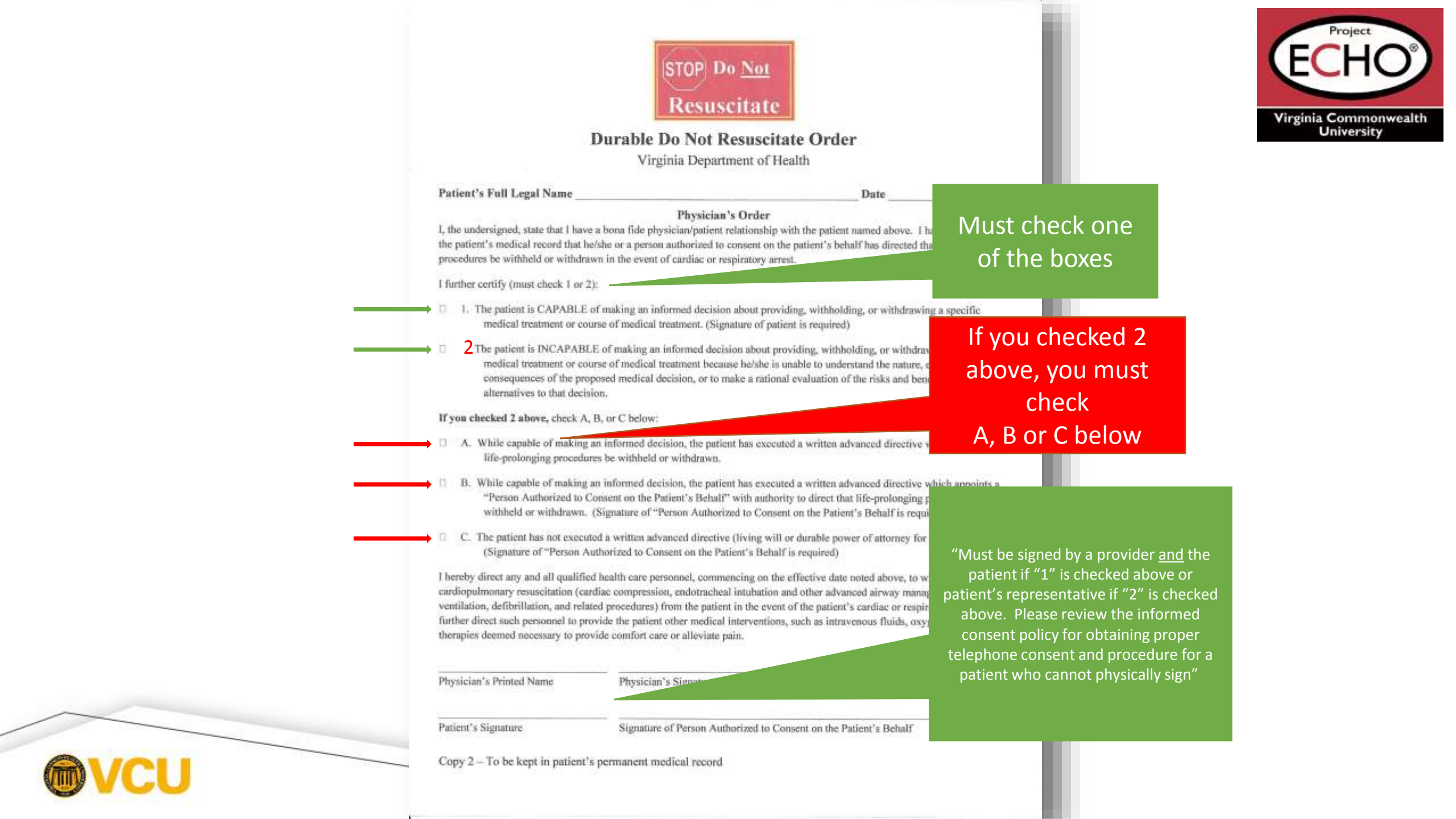
Who decides if no agent is appointed?

1. Legally appointed guardian
2. Patient's spouse (except where divorce action has been filed)
3. Adult children
4. Parent of patient
5. Adult siblings
6. Any blood relative in descending order of relationship

Do Not Resuscitate
DNR/DDNR

- **Inpatient**: A provider must enter a DNR order.

- **Outpatient:** Inpatient DNR orders do **not** follow a patient upon discharge. If the patient or Agent wishes to continue the patient's DNR status upon discharge, a provider must complete a paper Durable DNR (DDNR) form.


STOP Do Not Resuscitate
Durable Do Not Resuscitate Order
Virginia Department of Health
Patient's Full Legal Name
Date
Physician's Order
I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above.
the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed th
procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.
I further certify (must check 1 or 2):
1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)
2 The patient is INCAPABLE of making an informed decision about providing, withholding, or withdra
medical treatment or course of medical treatment because he/she is unable to understand the nature,
consequences of the proposed medical decision, or to make a rational evaluation of the risks and ben
alternatives to that decision.
If you checked 2 above, check A, B, or C below:
A. While capable of making an informed decision, the patient has executed a written advanced directive
life-prolonging procedures be withheld or withdrawn.
B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging
withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is requi
C. The patient has not executed a written advanced directive (living will or durable power of attorney for
(Signature of "Person Authorized to Consent on the Patient's Behalf is required)
I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to w
cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway mana
ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respir
further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxy
therapies deemed necessary to provide comfort care or alleviate pain.
Physician's Printed Name
Physician's Sign
Patient's Signature
Signature of Person Authorized to Consent on the Patient's Behalf
Copy 2 – To be kept in patient's permanent medical record
Must check one of the boxes
If you checked 2 above, you must check A, B or C below
"Must be signed by a provider and the patient if "1" is checked above or patient's representative if "2" is checked above. Please review the informed consent policy for obtaining proper telephone consent and procedure for a patient who cannot physically sign"

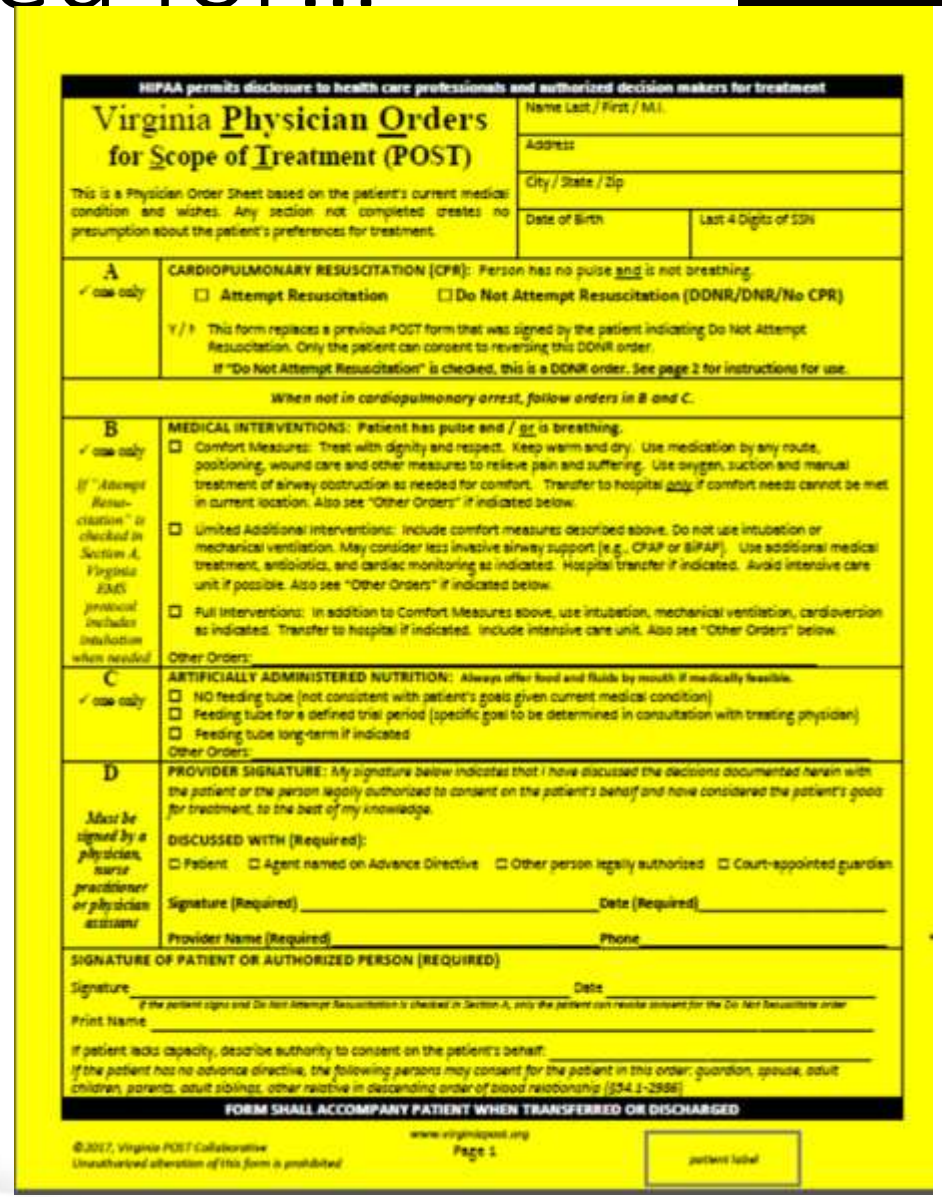
POST

Physician Orders for Scope of Treatment

- POST is a medical order set for patients with life-limiting illness or patients who are frail and elderly
- POST has a DNR section *plus* orders for other medical interventions to apply or withhold in pre-arrest situations depending on the wishes of the patient.
- POST is portable like the DDNR
- POST does not replace an Advance Directive. It builds upon and complements the patient's Advance Directive.

POST should be considered for…

- Any patient whose death within the next year would not come as a surprise.



HIPAA permits disclosure to health care professionals and authorized decision makers for treatment

Virginia Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the patient's current medical condition and wishes. Any section not completed creates no presumption about the patient's preferences for treatment.

Name Last / First / M.I.

Address

City / State / Zip

Date of Birth | Last 4 Digits of SSN

A ✓ one only

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

☐ Attempt Resuscitation ☐ Do Not Attempt Resuscitation (DDNR/DNR/No CPR)

Y / ♦ This form replaces a previous POST form that was signed by the patient indicating Do Not Attempt Resuscitation. Only the patient can consent to reversing this DDNR order.

If "Do Not Attempt Resuscitation" is checked, this is a DDNR order. See page 2 for instructions for use.

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

B ✓ one only

If "Attempt Resuscitation" is checked in Section A, Virginia EMS protocol includes intubation when needed

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

☐ Comfort Measures: Treat with dignity and respect. Keep 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. Also see "Other Orders" if indicated below.

☐ Limited Additional Interventions: Include comfort measures described above. Do not use intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP or BiPAP). Use additional medical treatment, antibiotics, and cardiac monitoring as indicated. Hospital transfer if indicated. Avoid intensive care unit if possible. Also see "Other Orders" if indicated below.

☐ Full Interventions: In addition to Comfort Measures above, use intubation, mechanical ventilation, cardioversion as indicated. Transfer to hospital if indicated. Include intensive care unit. Also see "Other Orders" below.

Other Orders: _____

C ✓ one only

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

☐ NO feeding tube (not consistent with patient's goals given current medical condition)

☐ Feeding tube for a defined trial period (specific goal to be determined in consultation with treating physician)

☐ Feeding tube long-term if indicated

Other Orders: _____

D

Must be signed by a physician, nurse practitioner or physician assistant

PROVIDER SIGNATURE: *My signature below indicates that I have discussed the decisions documented herein with the patient or the person legally authorized to consent on the patient's behalf and have considered the patient's goals for treatment, to the best of my knowledge.*

DISCUSSED WITH (Required):

☐ Patient ☐ Agent named on Advance Directive ☐ Other person legally authorized ☐ Court-appointed guardian

Signature (Required) _____ Date (Required) _____

Provider Name (Required) _____ Phone _____

SIGNATURE OF PATIENT OR AUTHORIZED PERSON (REQUIRED)

Signature _____ Date _____

If the patient signs and Do Not Attempt Resuscitation is checked in Section A, only the patient can revoke consent for the Do Not Resuscitate order

Print Name _____

If patient lacks capacity, describe authority to consent on the patient's behalf: _____

If the patient has no advance directive, the following persons may consent for the patient in this order: guardian, spouse, adult children, parents, adult siblings, other relative in descending order of blood relationship (§54.1-2986)

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

patient label

Sample ACP Documents

ACP Document 1

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, [redacted], willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II AND III BELOW.)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

A. Appointment of My Agent

I hereby appoint [redacted]

Home Address [redacted] Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

Name of Successor Agent E-mail Address

Home Address Telephone Number

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

B. Powers of My Agent

[IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.]

The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.
2. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive.
3. To employ and discharge my health care providers.
4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.
5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)
6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.

ACP Document 1

9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

IN A PROPER TIME PERIOD

SECTION II: MY HEALTH CARE INSTRUCTIONS

[YOU MAY USE ANY OR ALL OF PARTS 1, 2 OR 3 IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRITTEN INSTRUCTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS. IF YOU ARE AN EYE, ORGAN OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS, EYES AND TISSUE FOR DONATION.]

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

[CHECK ONLY 1 BOX IN THIS PART 1.]

[X] I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

[X] I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

[ ] *[YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

IF I BECOME BRAIN DEAD OR NOT RESPONDING TO TREATMENT

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment:

[CHECK ONLY 1 BOX IN THIS PART 2.]

[ ] I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

[ ] I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

[X] I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest 90 DAYS as the period of time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

[ ] *[YOU MAY WRITE HERE YOUR INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY. THIS INCLUDES SPECIFIC INSTRUCTIONS ABOUT TREATMENTS YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

ACP Document 1

3. I provide the following other instructions concerning my health care:

[YOU MAY WRITE HERE STATEMENTS AND INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR ABOUT TREATMENTS YOU DO NOT WANT UNDER SPECIFIC CIRCUMSTANCES OR ANY CIRCUMSTANCES. IT IS IMPORTANT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]

SECTION III: ANATOMICAL GIFTS

(YOU MAY USE THIS DOCUMENT TO RECORD YOUR DECISION TO DONATE YOUR ORGANS, EYES AND TISSUES OR YOUR WHOLE BODY AFTER YOUR DEATH. IF YOU DO NOT MAKE THIS DECISION HERE OR IN ANY OTHER DOCUMENT, YOUR AGENT CAN MAKE THE DECISION FOR YOU UNLESS YOU SPECIFICALLY PROHIBIT HIM/HER FROM DOING SO, WHICH YOU MAY DO IN THIS OR SOME OTHER DOCUMENT. CHECK ONE OF THE BOXES BELOW IF YOU WISH TO USE THIS SECTION TO MAKE YOUR DONATION DECISION.)

☐ I donate my organs, eyes and tissues for use in transplantation, therapy, research and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes or tissues for donation. I understand that I may register my directions at the Department of Motor Vehicles or directly on the donor registry, www.DonateLifeVirginia.org, and that I may use the donor registry to amend or revoke my directions; **OR**

☐ I donate my whole body for research and education.

[Write here any specific instructions you wish to give about anatomical gifts.]

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

03/07/2017 [redacted]
Date

The declarant signed the foregoing advance directive in my presence. *(TWO ADULT WITNESSES NEEDED)*

[redacted]

[redacted]

[redacted]

This form satisfies the requirements of Virginia's Health Care Decisions Act. If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk with an attorney. It is your responsibility to provide a copy of your advance directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends. For information on storing this advance directive in the free Virginia Advance Health Directive Registry, go to http://www.VirginiaRegistry.org. This form is provided by the Virginia Hospital & Healthcare Association as a service to its members and the public. (June 20[redacted]ha.com) ▲❋❋

ACP Document 2

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, [redacted], willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II AND III BELOW.)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

A. Appointment of My Agent Equal 1-2. both

I hereby appoint [redacted]

1 [redacted]

as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

2 [redacted]

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

B. Powers of My Agent

(IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.)

The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.
2. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive.
3. To employ and discharge my health care providers.
4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.
5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)
6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
8. X To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.

Project ECHO Virginia Commonwealth University

VCU

ACP Document 2

9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

SECTION II: MY HEALTH CARE INSTRUCTIONS

[YOU MAY USE ANY OR ALL OF PARTS 1, 2 OR 3 IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRITTEN INSTRUCTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS. IF YOU ARE AN EYE, ORGAN OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS, EYES AND TISSUE FOR DONATION.]

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

[CHECK ONLY 1 BOX IN THIS PART 1.]

☐ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

☒ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

☐ *[YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment:

[CHECK ONLY 1 BOX IN THIS PART 2.]

☐ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

☐ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

☐ I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest _____ as the period of time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

☑ *[YOU MAY WRITE HERE YOUR INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY. THIS INCLUDES SPECIFIC INSTRUCTIONS ABOUT TREATMENTS YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

If I am termined, have uncontroled pain or cannot communicate. I want only palliative care. If any hope of a change in condition I want to be treated.

ACP Document 2

3. I provide the following other instructions concerning my health care:
(YOU MAY WRITE HERE STATEMENTS AND INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR ABOUT TREATMENTS YOU DO NOT WANT UNDER SPECIFIC CIRCUMETANCES OR ANY CIRCUMSTANCES. IT IS IMPORTANT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.)

SECTION III: ANATOMICAL GIFTS

(YOU MAY USE THIS DOCUMENT TO RECORD YOUR DECISION TO DONATE YOUR ORGANS, EYES AND TISSUES OR YOUR WHOLE BODY AFTER YOUR DEATH. IF YOU DO NOT MAKE THIS DECISION HERE OR IN ANY OTHER DOCUMENT, YOUR AGENT CAN MAKE THE DECISION FOR YOU UNLESS YOU SPECIFICALLY PROHIBIT HIMHER FROM DOING SO, WHICH YOU MAY DO IN THIS OR SOME OTHER DOCUMENT. CHECK ONE OF THE BOXES BELOW IF YOU WISH TO USE THIS SECTION TO MAKE YOUR DONATION DECISION.)

☑ I donate my organs, eyes and tissues for use in transplantation, therapy, research and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes or tissues for donation. I understand that I may register my directions at the Department of Motor Vehicles or directly on the donor registry, www.DonateLifeVirginia.org, and that I may use the donor registry to amend or revoke my directions; OR

☐ I donate my whole body for research and education.

[Write here any specific instructions you wish to give about anatomical gifts.]

I am Hep C antibody positive. But wish to donate if possible.

AFFIRMATION AND RIGHT TO REVOKE:

By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

7-26-2016 [redacted]
Date

The declarant signed the foregoing advance directive in my presence. *(TWO ADULT WITNESSES NEEDED)*

[redacted] [redacted]

Witness Signature Witness Printed

This form satisfies the requirements of Virginia's Health Care Decisions Act. If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk with an attorney. It is your responsibility to provide a copy of your advance directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends. For information on storing this advance directive in the free Virginia Advance Health Directive Registry, go to http://www.VirginiaRegistry.org. This form is provided by the Virginia Hospital & Healthcare Association as a service to its members and the public. (June 2012, www.vhha.com) ▲●■

ACP Document 3

[redacted]

DURABLE POWER OF ATTORNEY

OF

[redacted]

I. PRINCIPAL AND ATTORNEY-IN-FACT

I, [redacted], who resides at [redacted], hereby revoke any general power of attorney that I have heretofore given to any person and do hereby appoint [redacted] residing at [redacted] to serve as my attorney-in-fact, to act for me in any lawful way with respect to the subjects indicated below.

If [redacted] resigns or is unable or unwilling to serve as my attorney-in-fact, I appoint [redacted] to serve as my successor attorney-in-fact.

II. EFFECTIVE TIME

This Power of Attorney shall become effective immediately and shall continue to be effective until my death or until revoked. In the event of my disability or incompetency, from whatever cause, this power of attorney shall not thereby be revoked.

III. POWERS OF ATTORNEY-IN-FACT

My attorney-in-fact shall have the power to act in my name, place and stead in any way which I myself could do with respect to the following matters to the extent permitted by law:

A. BANKING TRANSACTIONS:
Conduct any business with banks and other financial institutions, including but not limited to the following:

- Signing and endorsing all checks and drafts in my name.
- Withdrawing funds from accounts.
- Opening, maintaining and closing accounts or other banking arrangements.
- Making inquiries regarding existing accounts.
- Hiring safe deposit boxes, entering into and removing articles from them.
- Borrowing money, pledging property as security, and negotiating terms of debt payments.
- Applying for and receiving letters of credit, credit cards and travel's checks, and giving an indemnity or other agreement in connection with letters of

ACP Document 3

credit.

B. STOCK AND BOND TRANSACTIONS:

- Buy, sell, pledge and exchange stocks, mutual funds, bonds, options, commodity futures and all other types of securities in my name.
- Sign, accept and deliver in my name certificates, contracts or other documents relating to the foregoing, including agreements with brokers or agents.
- Exercise voting and other rights and enter into agreements relating thereto.

C. REAL ESTATE TRANSACTIONS:

- Manage, sell, transfer, lease, mortgage, pledge, refinance, insure, maintain, improve, and perform any and all other acts with respect to real property and interests in real property that I may own now or later acquire.
- Defend, settle and enforce by litigation a claim to real property and interests in real property that I own now or later acquire.
- Buy, lease or otherwise acquire real property or an interest in real property.
- Execute deeds, mortgages, releases, satisfactions and other instruments relating to real property and interests in real property that I own or later acquire.

D. PERSONAL PROPERTY TRANSACTIONS:

- Buy or otherwise acquire ownership or possession of, sell or otherwise dispose of, mortgage, pledge, assign, lease, insure, maintain, improve, pay taxes on, and otherwise manage tangible personal property and interests thereof that I now own or later acquire.

E. PERSONAL AND FAMILY CARE:

- To do all acts necessary to maintain the customary standard of living of my spouse and myself, including but not limited to, providing and paying for medical care, shelter, clothing, food, transportation, airfare and dues for organizations to which I hold membership.
- To authorize my admission to a medical, nursing, residential, or similar facility and to enter into agreements for my care, and to authorize medical and surgical procedures for me.
- Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any similar state laws, I authorize any health care provider to disclose to the person named herein as my "attorney-in-fact," any pertinent individually identifiable health information. My attorney-in-fact shall constitute my "Personal Representative" as defined by HIPAA.

qualifies as HOA 72

ACP Document 3

F. GOVERNMENT ASSISTANCE:

- Claim and collect benefits from social security, Medicare, Medicaid, or other government programs or civil or military.

G. INSURANCE AND ANNUITY TRANSACTIONS:

- Obtain, modify, renew, convert, rescind, pay the premium on or terminate insurance and annuities of all types for myself and for my family and other dependents.
- Designate the beneficiary of the contract, but the attorney-in-fact may be named beneficiary under a contract, or an extension, renewal, or substitute for it, only to the extent the attorney-in-fact was named as a beneficiary under a contract procured by the principal before signing this Power of Attorney.
- Surrender and receive the cash value, borrow against or pledge any insurance or annuity policy.

H. ESTATE AND TRUST TRANSACTIONS:

- To act for me in all matters that affect a trust, probate estate, guardianship, conservatorship, escrow, custodianship or other fund from which I am now, claim to be or later become entitled, as beneficiary, to a share or payment.

I. LEGAL ACTIONS:

- To act for me in all legal matters, whether claims in my favor or against me, including but not limited to retaining attorneys on my behalf; appearing for me in all actions and proceedings, commencing actions in my name, signing all documents, submitting claims to arbitration or mediation, settling claims and paying judgments and settlements.

J. TAXES:

- Prepare, exercise any available election, and sign tax returns and related documents.
- Pay taxes due, collect refunds, post bonds, receive confidential information.
- Represent me in all income tax matters before any federal, state or local tax collecting agency.

K. RETIREMENT PLANS:

- To act for me in all matters that affect my retirement or pension plans, including but not limited to selecting payment options, designating beneficiaries, making contributions, exercising investment powers, making "rollovers" of plan benefits, borrowing or selling.

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IV. GENERAL PROVISIONS

1. Reliance By Third Parties. I hereby agree that any third party receiving a duly executed copy or copy of this document, may rely on and act under it. Revocation or termination of this Power of Attorney shall be ineffective as to the third party unless and until actual notice or knowledge of that revocation or termination has been received by the third party. I, for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any third party from any and all claims because of reliance on this instrument in good faith.

2. Severability. If any provision hereof is found to be invalid or unenforceable, such invalidity or unenforceability shall not affect the other provisions of this document, and such other provisions shall be given effect without the invalid or unenforceable provision.

3. Revocation. I may revoke the Power of Attorney at any time.

4. Accounting. My attorney-in-fact shall provide an accounting for all funds handled and all acts performed as my attorney-in-fact, but only upon my request or the request of a personal representative or fiduciary acting on my behalf. Any requirement of my attorney-in-fact to file inventories and accounts with the county clerk or with the court is specifically waived.

5. Compensation and Reimbursement. My attorney-in-fact shall not be compensated for services provided on my behalf pursuant to this Power of Attorney. My attorney-in-fact shall be reimbursed for all reasonable expenses incurred relating to his or her responsibilities.

6. Personal Benefit Permitted. So long as my attorney-in-fact is acting in good faith and in my best interest, my attorney-in-fact is permitted to personally benefit or profit from transactions taken on my behalf.

7. Commingling of Funds. My attorney-in-fact is not permitted to commingle my funds and assets with his or her own.

8. Liability of Attorney-in-Fact. All persons or entities who in good faith endeavor to carry out the provisions of this Power of Attorney shall not be liable to to me, my Estate, or my heirs, for any damages or claims arising because of their actions or inactions based on this Power of Attorney. My Estate shall indemnify and hold them harmless. A successor attorney-in-fact shall not be liable for acts of a prior attorney-in-fact.

ACP Document 3

IN WITNESS WHEREOF, the undersigned has executed Power of Attorney on the date set forth below.

Date: 6/11/2010

Signature of [redacted]

ACKNOWLEDGMENT OF NOTARY PUBLIC

Commonwealth of Virginia

County of [redacted]

On this 11 day of JUNE, 2010, before me, the undersigned Notary Public, personally appeared [redacted] personally known to me (or proved to me on the basis of satisfactory evidence) to be the individual who signed the foregoing Power of Attorney and acknowledged to me that he or she executed the same in his or her authorized capacity, and that by such signature, the person executed the instrument.

Witness my hand and seal.

Signature of Notary Public: [redacted]

[redacted]

needs another witness for HPOA

This document was prepared by:

[redacted]

ACP Document 4

STOP Do Not Resuscitate

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name [redacted] **Date** 8/26/2017

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☑ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

[redacted]

Physician's Printed Name | Physician's Signature | Emergency Phone Number

atient's Signature | [redacted] Signature of Person Authorized to Consent on the Patient's Behalf

Copy 1 – To be kept by patient

ACP Document 4

STOP Do Not Resuscitate

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name [redacted] **Date** 9/5/2017

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

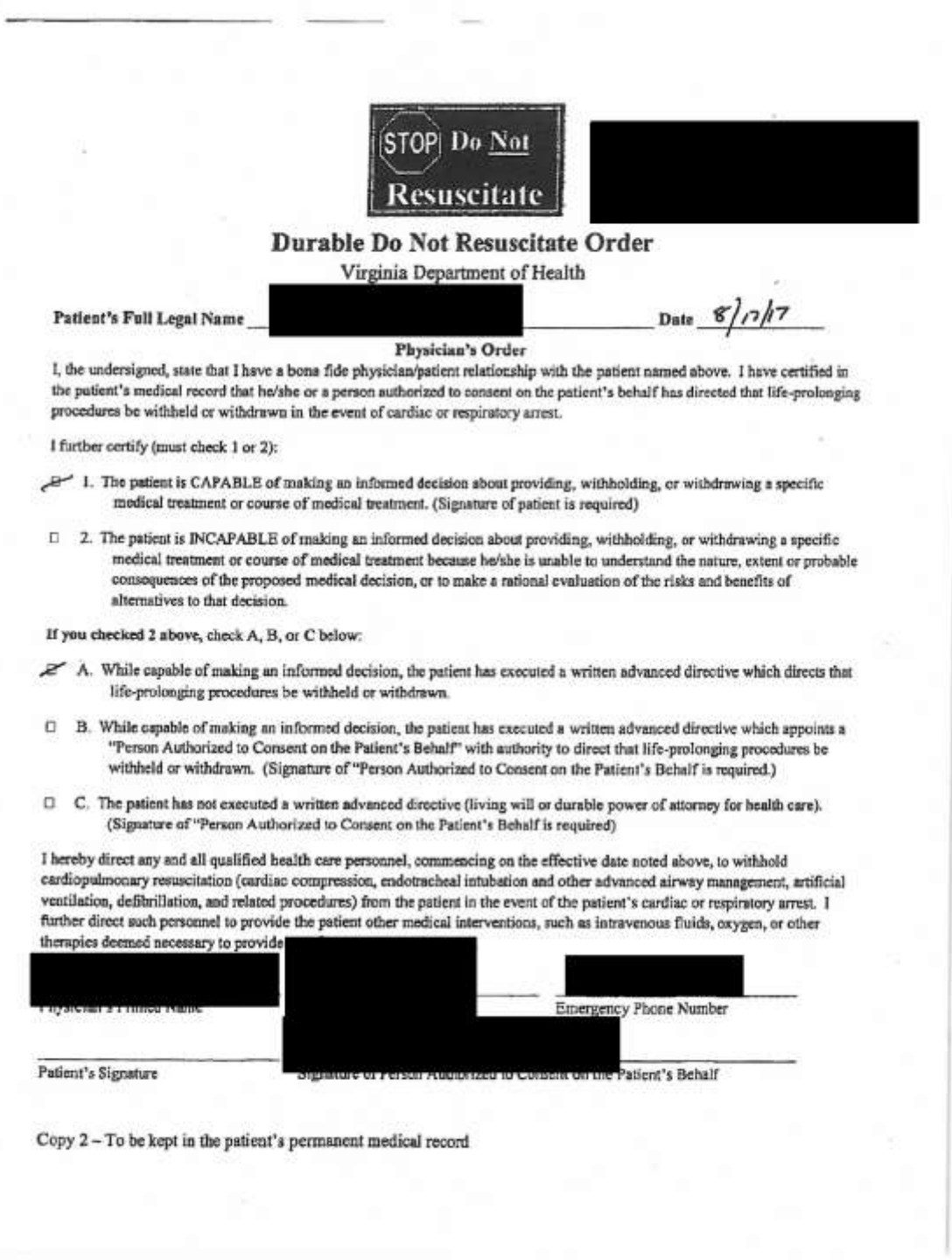
[redacted] Emergency Phone Number

[redacted]

Patient's Signature Signature of Person Authorized to Consent on the Patient's Behalf

Copy 2 – To be kept in the patient's permanent medical record

ACP Document 5



STOP Do Not Resuscitate

[redacted]

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name [redacted] **Date** 8/17/17

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☑ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

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☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide

[redacted] [redacted] [redacted]

Physician's Printed Name Emergency Phone Number

Patient's Signature Signature of Person Authorized to Consent on the Patient's Behalf

Copy 2 – To be kept in the patient's permanent medical record

How do I begin a conversation about ACP? Explain:

- All individuals ≥18 should plan ahead for an unexpected injury or illness that leaves them unable to make healthcare decisions for themselves. Planning includes:
- Doing this well in advance of the emergency.
- Selecting a healthcare decision maker, an Agent, that is well suited for the role
- Having enough conversation with their Agent so that the decisions their Agent makes for them are in alignment with the decisions they would make for themselves if they were able.
- Include the Agent and other family and loved ones if possible.

Selecting the Healthcare Agent: Important considerations

- Have I asked this person if he/she is willing?
- Have I talked with this person enough so that he/she understands my preferences, values, and goals?
- Will this person follow my preferences, even if they differ from their own?
- Can this person ask questions and make decisions in difficult or emotional situations? Can they keep a “cool head” in a crisis? Can they stand up for me with the healthcare team and family members and other loved ones who might disagree?

Try Asking These Questions

For all patients:

- "What experiences have you had with people that have been seriously ill? Have you, or anyone close to you ever had to make decisions for a loved one who could no longer speak for him or herself? What did that experience teach you about what you would want and not want if you were ever in the same situation?"

- "What level of physical and mental function do you need in order to have a good quality of life? What gives your life meaning?"

For patients with serious chronic and progressive or life limiting illness:

- "What fears or concerns do you have about your illness going forward?"

- "What are your goals for care and treatment as you move forward?" (Explore the difference between quantity and quality of life.)

Clarify the meaning of words and phrases!

Resources

- Virginia State Bar. (2014). Healthcare Decisions Day. Retrieved from http://www.vsb.org/site/public/healthcare-decisions-day

- Critical Conversations:
  ACP Tools for Physicians, NPs and PAs
  https://honoringchoices-va.org/courses/critical-conversations/

Case Presentation

Alison Ryan

VCUHealth

Case 1: Question

What is the nature of your question?

Treatment options (goals of care); Advance Care Planning

Main question:

In the case of a young patient with metastatic disease at diagnosis, discuss options for when goals of care, advance care planning should be initiated.

At what point do we opt not to pursue further anticancer therapy?

Case 1: History

Brief history of illness and other comorbid disorders

43 yo diagnosed with Stage IV triple negative breast cancer July 2018, s/p 4 c ddAC, s/p weekly taxol, Carbo with progression 1/19. Phase 2 Clinical trial therapy, 1 cycle Pemetrexed/Sorafenib with rapid progression of hepatic metastasis.

Admitted for 2nd time in 2 weeks with abdominal pain, progressive N/V. significant progressive hepatic dysfunction due to disease burden. Patient then received fixed dose capecitabine for 3 days prior to discharge home, expiring at home two days later.

Case 1

Patient social and spiritual history

Patient lived at home with teenage child, older daughter out of the house. Currently disabled. Very involved mother providing care and support.

Patient Symptom Assessment

Pain

Agitation

Nausea

Constipation

Delirium

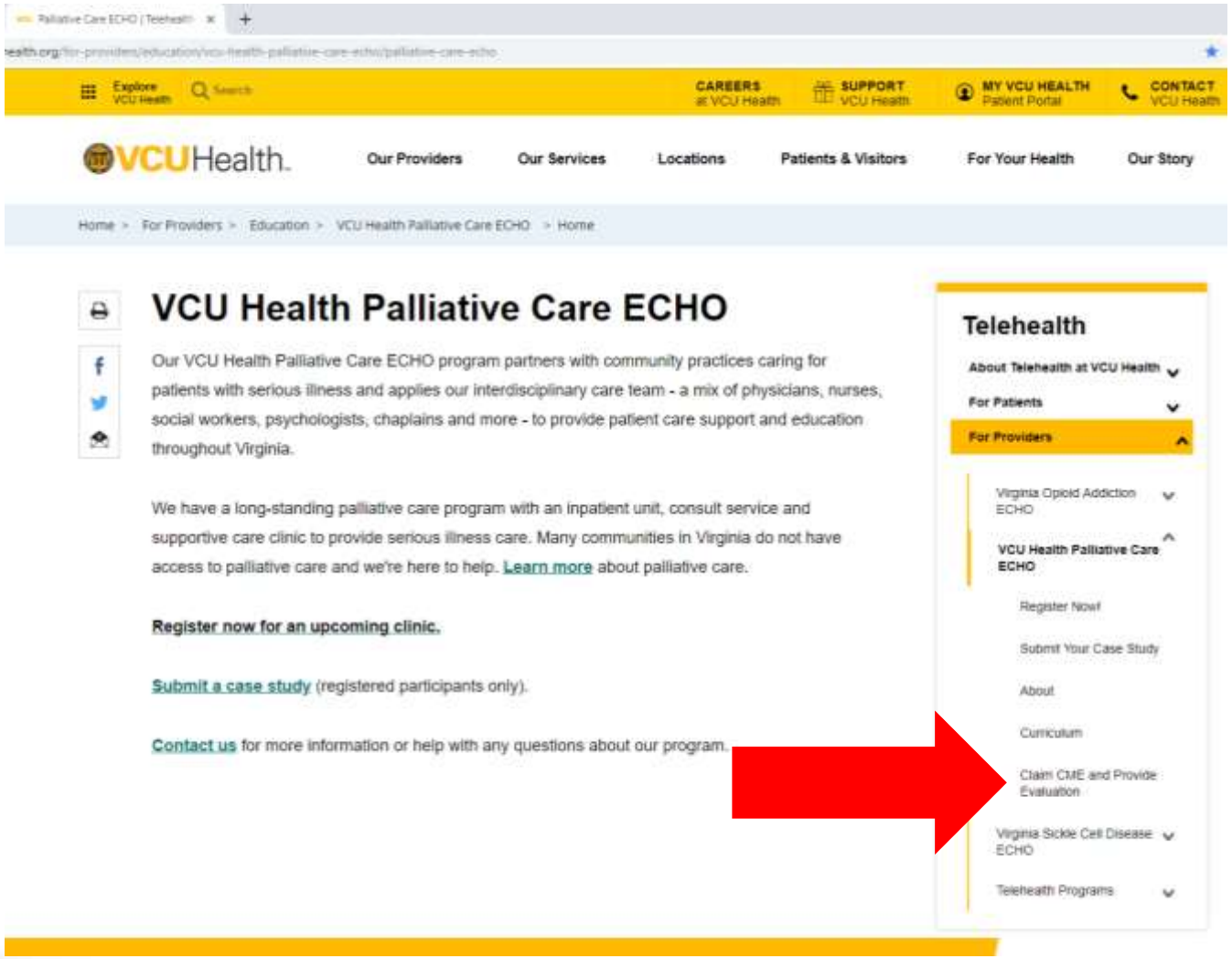
Advance Directive completed 3/1
Durable DNR order completed 3/1

Accessing CME credit

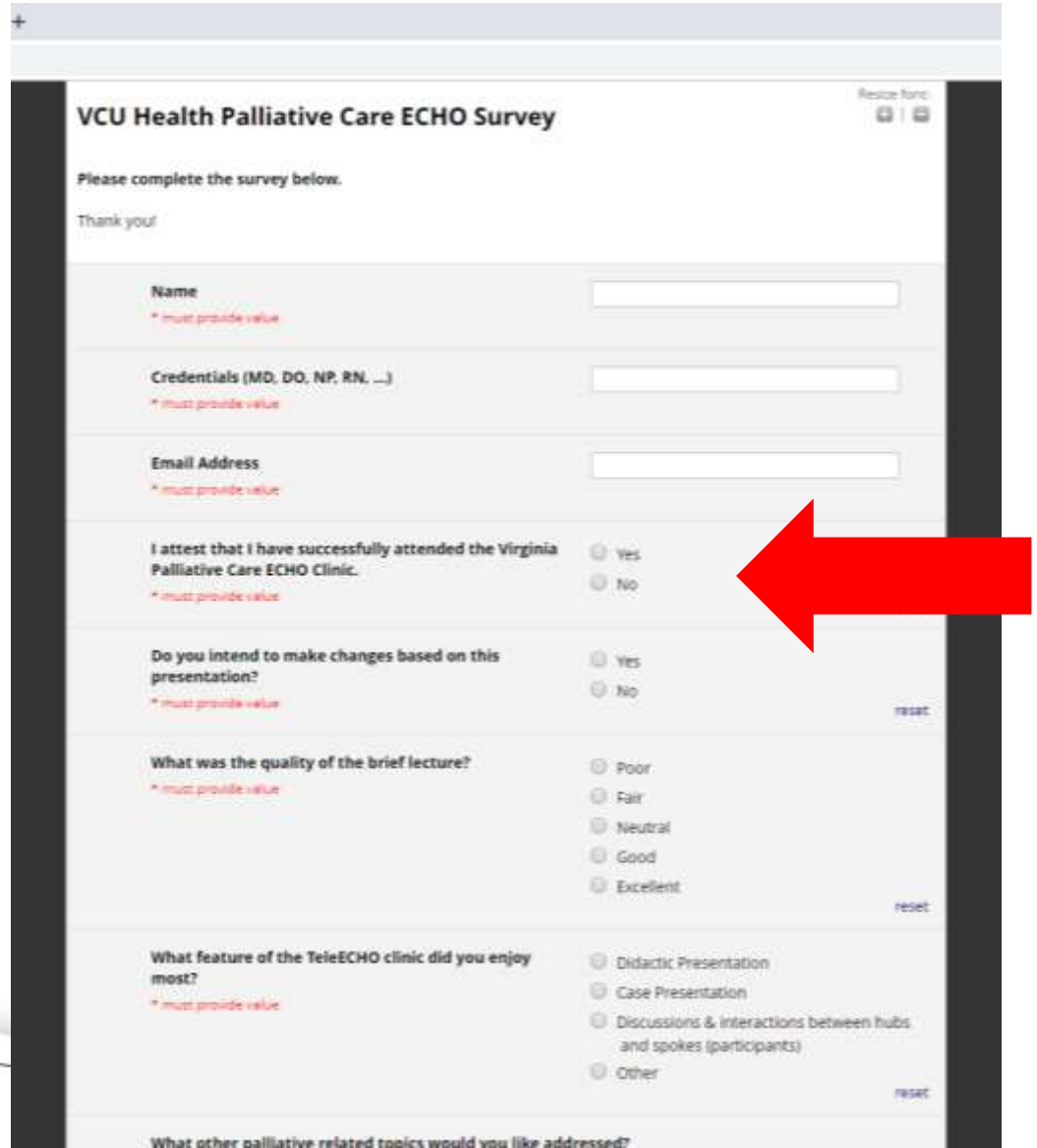
Submit your evaluation to claim your CME

After our live ECHO session, visit www.vcuhealth.org/pcecho

Click “Claim CME and Provide Evaluation”



Submit your evaluation to claim your CME



VCU Health Palliative Care ECHO Survey

Please complete the survey below.

Thank you!

Name
* must provide value

Credentials (MD, DO, NP, RN, ...)
* must provide value

Email Address
* must provide value

I attest that I have successfully attended the Virginia Palliative Care ECHO Clinic.
* must provide value
- Yes
- No

Do you intend to make changes based on this presentation?
* must provide value
- Yes
- No

reset

What was the quality of the brief lecture?
* must provide value
- Poor
- Fair
- Neutral
- Good
- Excellent

reset

What feature of the TeleECHO clinic did you enjoy most?
* must provide value
- Didactic Presentation
- Case Presentation
- Discussions & interactions between hubs and spokes (participants)
- Other

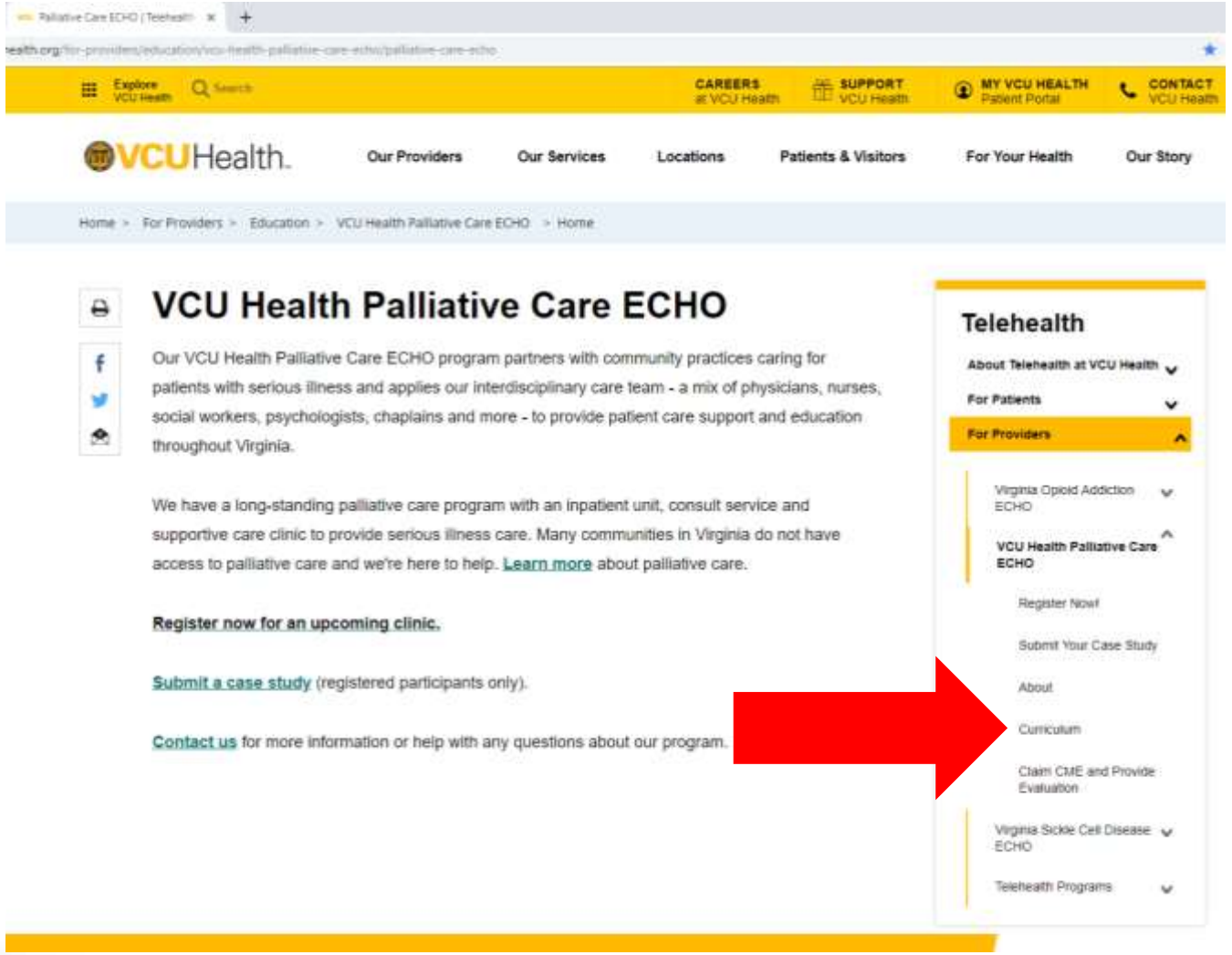
reset

What other palliative related topics would you like addressed?

View previously recorded ECHOs for CME

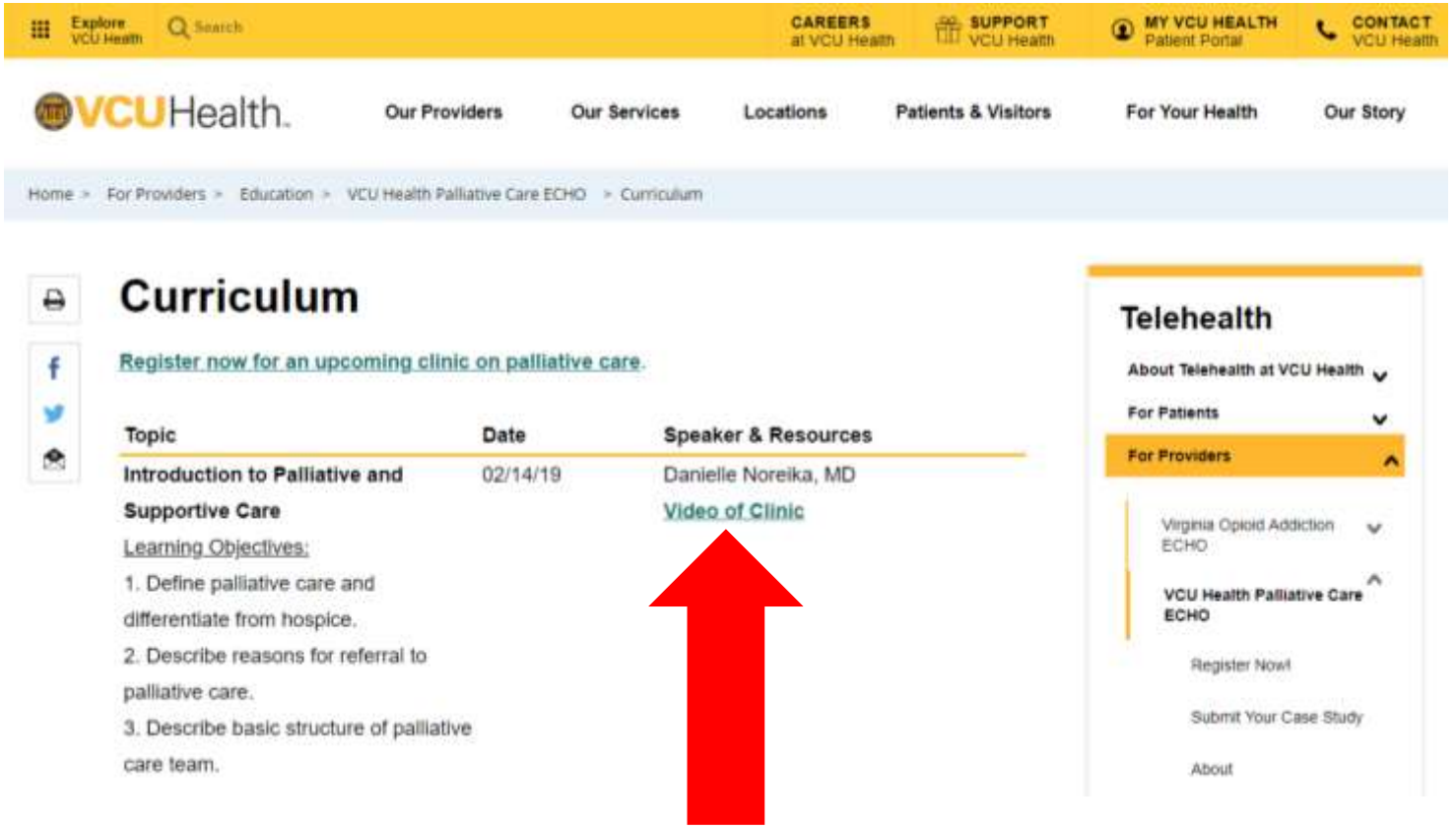
To view previously recorded sessions and claim credit, visit www.vcuhealth.org/pcecho

Click “Curriculum”



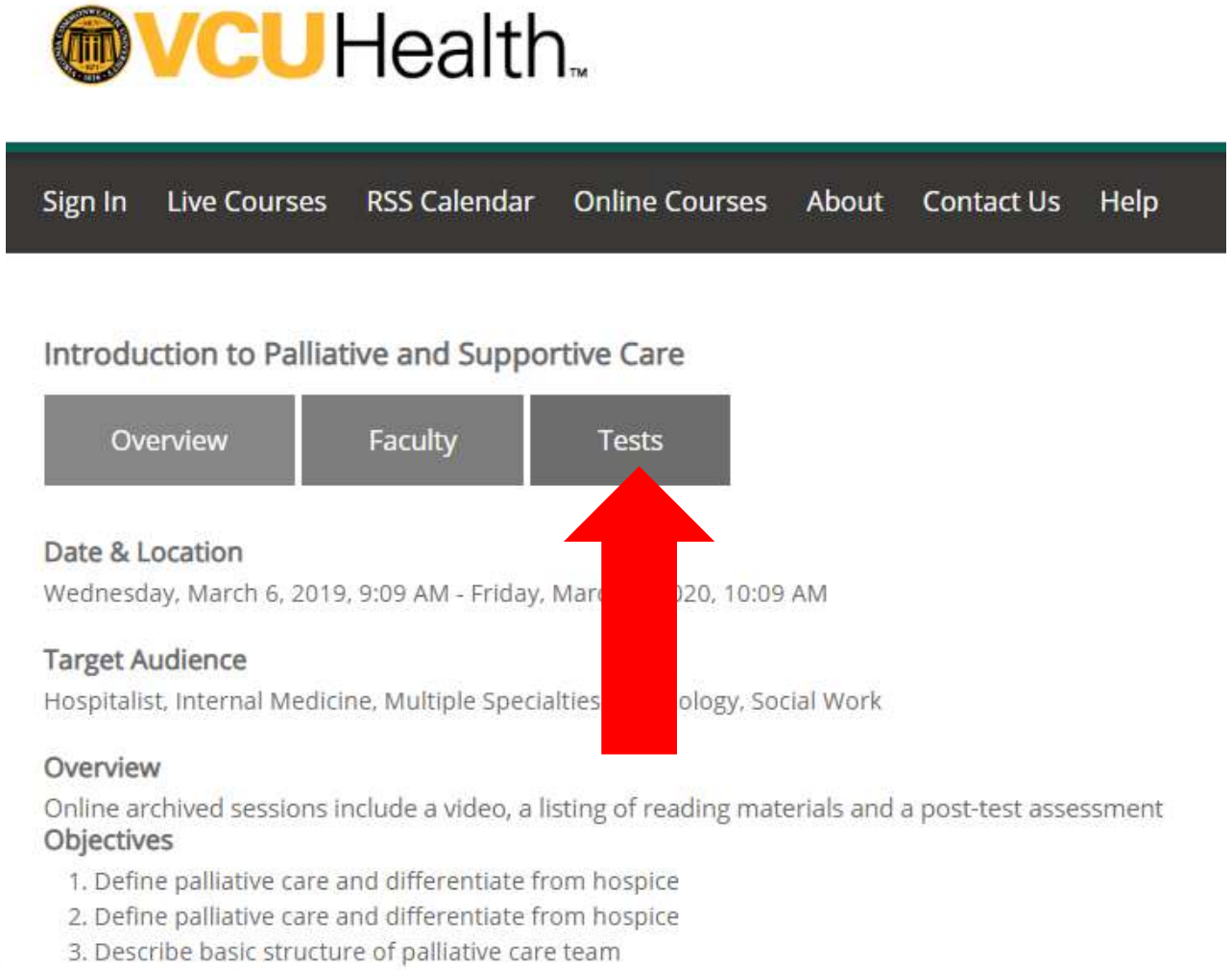
View previously recorded ECHOs for CME

Select the session you would like to view



View previously recorded ECHOs for CME

Click “Tests” to view video of the session and take a short quiz for continuing education credit



THANK YOU!

We hope to see you at our next ECHO