Supporting Safe Passage

The Power of Advance Care Planning

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Objectives

- Recognize evidence supporting the value of advance care planning
- Describe artful ways to initiate discussions related to advance care planning
- Define capacity to consent and advance directive forms

Questions

- What is a good death?
- Does advance care planning really make a difference in “safe passage”?
- How do we manage conversations about end of life?
- What forms should be completed?

"A Good Death"
Truth or Oxymoron?

Simply defined
good care at end of life
IOM.1997

Advance Care Planning
Key to a "good death"

Most people want to die at home. But only about one-third of adults have an Advance Directive (AD) expressing their wishes for end-of-life care (Pew 2006, AARP 2008)

- Completion of AD
  - Home health patients—28% (Jones 2011)
  - Nursing home residents—65% (Jones 2011)
  - Hospice patients—88% (Jones 2011)
- Severely ill patients-->50% documented in EMR
  - 65-76% of physicians whose patients had an AD were not aware of it (Kass-Bartelmes 2003)

Advance Care Planning

- Discussions regarding health care that centers around one's life values, goals and treatment choices.
- Periodic revisiting of one's perceptions over time
- Provides a framework for matching subsequent care decisions with the patient's wishes
- These wishes usually become more specific as serious illness advances.
- Empowering a trusted surrogate decision-maker to make decisions consistent with your wishes

What are the barriers?

- Lack of Awareness
- Denial
- Confusion
- Cultural Differences

EOL Cultural Differences

Ethnicity	Desire to Die in the Hospital	Desire for Aggressive Therapies	Desire for Palliative Care	Desire for Mechanical Ventilation
Black	18%	28%	49%	24%
Hispanic	15%	21%	57%	22%
White	8%	15%	74%	13%

Which of the following outcomes occurred when healthcare providers had conversations with patients about their end-of-life goals?

1. Increased feelings of depression.
2. Less likely to believe they had a terminal illness.
3. Higher risk of depression in the bereaved caregivers.
4. Over twice as likely to complete DNR advance directive.

Wright, et al. JAMA. Oct. 2008

Dana-Farber Cancer Institute Study

- **Did EOL discussions result in**
- **fewer aggressive interventions before death?**

Enrollment
- 332 patients from 7 cancer centers

All patients died
- Within 4.4 months of enrollment

Within 3 weeks after patient's death
- Medical record was reviewed for indicators of aggressive medical care

Wright, et al. JAMA. Oct. 2008

Effect of EOL Discussions

	Discussions were offered YES	NO
More likely to accept that illness was terminal	52.9%	28.7%
ICU admission	0.8%	12.4%
Preferred treatment focused on comfort over life-prolonging therapy	85.4%	70%
Completed DNR order	63%	28.5%
Earlier hospice enrollment	65.5%	44.5%

When is the Right Time?

It’s too early until it’s too late!!

Typical Decision Points

- Diagnosis of a potentially serious illness
- Admission into a healthcare setting
- When faced with treatment options
- At the point of medical futility
- At any time

Would you be surprised if this patient died in the next year?

Starting the Conversation

Artful Ways to Initiate ACP

- Schedule a time with this as the agenda. Sit down. Slow down.
- Ensure the appropriate decision makers are present
- Address older adults directly when family members are present
- Be sensitive to cultural diversity
- Make no assumptions. Clarify. Restate. Ask individuals to repeat what they heard you say.
- Use a team approach.
- Use interpreters as needed—medical translators
  - Family members are often not the best interpreters

Advanced Illness Checklist

- Prognosis
  - What is your understanding of where you are and what the future may hold with your illness?
- Information
  - How much information do you want to know?
- Fears/worries:
  - What are your biggest fears about the future?

Advanced Illness Checklist

- Tradeoffs
  - If you become sicker, how much are you willing to go through, in terms of machines, procedures, hospitalizations, in order to have the possibility of more time to live?
- Function
  - Are there specific health states that you would find unacceptable? For example, being on machines, in a coma, or unable to care for yourself?
- Family
  - How much have you discussed your goals and wishes with your family?

Capacity to Consent

- Adults are presumed capable unless proven otherwise
  - Evaluate ability to understand relevant information
  - Evaluate ability to understand consequences of a decision
  - Irrationality and incapacity are not the same thing
- Capacity may be transient
  - Delirium, drugs, sleep deprivation, anger, depression, underlying illness
  - Reversible causes must be evaluated and treated

Healthcare Power of Attorney

A legal form that allows an individual to empower another with decisions regarding his or her healthcare and medical treatment. Healthcare power of attorney becomes active when a person is unable to make decisions or consciously communicate intentions regarding treatments.

Identifying a health care proxy or agent

- Are they willing to do it?
- Do they know your values?
- Are they willing to honor your wishes?
- Are they comfortable in a health care setting?
- Do they live close by?
- If not, are they willing to fly?

Surrogate Decision Maker/Proxy

A health care proxy, or agent, who advocates for an incompetent patient.

1. Competent spouse
2. Adult children;
3. Parents
4. Adult siblings
5. Adult grandchildren
6. Close friends
7. Physicians

Living Will

A legal document that sets out the medical care an individual wants or does not want in the event that he or she becomes incapable of communicating his or her wishes.

Medical Decisions

- DNR/DNI
- Renal dialysis
- Intubation, ventilator
- Antibiotics
- Artification nutrition
- Feeding tube

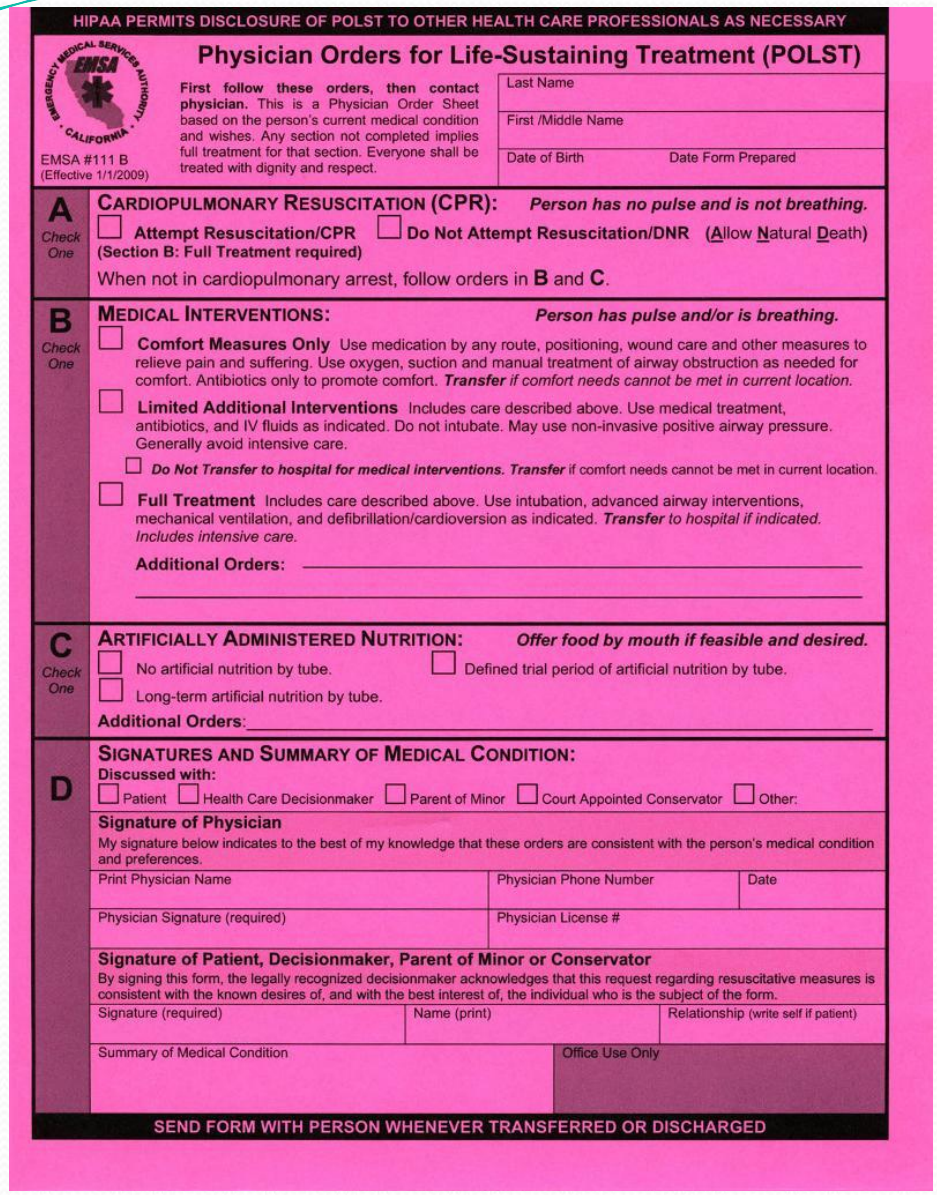
Communicate your values and goals

- What do you want to accomplish in your life?
- What makes life worth living for you?
- What would make life not worth living?
- What do you hope for now and in the future?
- What do you hope for your spouse and/or children?
- When you are nearing the last days of your life, what do you think will be most important to you?

POLST-Physician Orders for Life Sustaining Treatment

Legal document for people with advanced illnesses that specifies the type of care a person would like in an emergency medical situation

- Began in 1991 in Oregon
- Designed for individuals with terminal illness
- Physician or medical orders
- Designed to honor the treatment wishes of **patients across care sites.**
- CPR, medical interventions, antibiotics, hydration and nutrition
- 36 states have some form of physician orders



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2009)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name
First /Middle Name
Date of Birth Date Form Prepared

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** ***Person has no pulse and is not breathing.***

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)
(Section B: Full Treatment required)

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

B Check One — **MEDICAL INTERVENTIONS:** ***Person has pulse and/or is breathing.***

☐ **Comfort Measures Only** 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. Antibiotics only to promote comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Do Not Transfer to hospital for medical interventions. Transfer*** if comfort needs cannot be met in current location.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** ***Offer food by mouth if feasible and desired.***

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D — **SIGNATURES AND SUMMARY OF MEDICAL CONDITION:**

Discussed with:
☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other:

Signature of Physician
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Decisionmaker, Parent of Minor or Conservator
By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)

Summary of Medical Condition	Office Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

POLST

Have You Completed Your Plan?

"Planning is bringing the FUTURE into the PRESENT so that you can do something about it now."

Alan Lakein

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