Advance Care Planning: A Good Step for All

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Objectives

- Describe the components of advance care planning
- Describe the FL law regarding advance directive options
- Describe the difference between an advance directive and a physician's order

Our Laws Support ACP

- US Supreme Court 1990
- Patient Self-determination Act, 1997
- FL Statute 765
  - Living Will
  - Health Care Surrogate
  - Durable Power of Attorney for Health Care
- DNRO “Yellow Form” (FL Statute 409)

Not Just for Older Folks

Karen Quinlan **Nancy Cruzan** **Terri Schiavo**

Reasons to Plan Ahead

- The future is known – we will die
- Things happen while dying that people do not like
  - May not get treatment wanted
  - Not making a decision is making a decision
- People want to have a say in what happens in the future
- These decisions are something <u>everybody</u> should talk more about

Advance Care Planning

- A process over time
- Discussing and documenting goals and values
- Discussing and documenting desires and wishes for future medical care
- Used when the patient can't make his/her own decisions
- Should be a routine part of medical care

It is NOT about completing forms

Why Do We Need to Understand Values?

- Because we are caring for more than just a biological organism
- Many variables that can alter judgment about whether a treatment is of benefit to the patient
- A health professional's duty is to do what is good for the patient, knowing patient goals, values and beliefs is an essential part of good care
- When values are used for decision-making it builds authenticity

Value-Based Decision-Making

What qualities in life do you value?

Mobility

Comfort

Family

Longevity

Independence

Spirituality

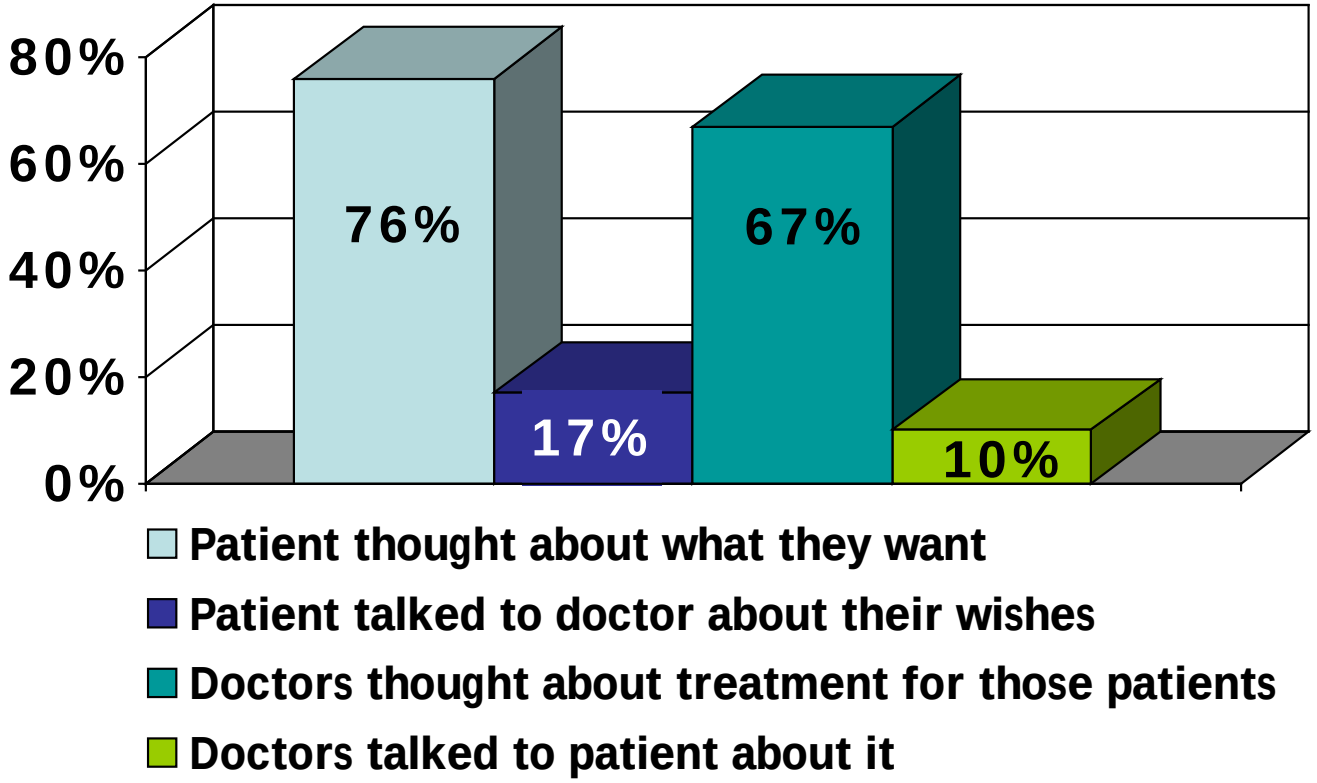
Wealth

Mental Capacity

Understanding Goals & Wishes

- What is most important in your life now?
- What experiences have you had with serious illness?
- Which fits your values?
  - Treat intensively even if it means suffering to try to extend life
  - Use medical treatments but stop if you are suffering, even if it means a shorter life
  - Use all measures to promote comfort, even if it means a shorter life
- Can you imagine a health situation that would be worse than death?
- Have you changed your mind about what is important over time?

Talking About End-of-life Treatment Decisions



Survey:
75 year-old patients and their physicians

Kohn M. Menon G. Life prolongation: views of elderly outpatients and health care professionals. *JAGS;36(9):840-4, 1988*

Advance Care Plans

- Health Care Surrogate
- Advance Directive
  - Living will, or
  - 5 Wishes, or
  - Advance Care Planning Document
- Drs. Orders

Ultimate goal: support the patient's autonomy

Health Care Surrogate

- Name someone who can be trusted to follow the patient's wishes
  - "Someone who can live without you"
- Someone who is available
- Patient and surrogate must discuss goals and values
- Ask the surrogate if they can do it

See FL Surrogate form

Florida Definitions

- **Health care surrogate** - someone expressly named to make health care decisions for the patient
- **Proxy** - someone who has not been expressly named
- Durable power of attorney for health care -essentially the same as a surrogate

FL Statutes 765

Who's the Proxy?

1. Legal guardian
2. Spouse
3. Adult child
4. Parent
5. Adult sibling
6. Adult relative
7. Close friend
8. Clinical SW

FL Statutes 765

Living Will

- A expression of wish to die naturally if:
  - Terminal condition
  - End-stage condition
  - Persistent vegetative state
- No reasonable hope for recovery
- Problems:
  - Vague terms
  - Two physicians must document state

See FL Living Will form

FL Statute Definitions

- Terminal Illness
  - A condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

FL Statute Definitions

- End-stage Condition
  - An irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

FL Statute Definitions

- Persistent Vegetative State
  - A permanent and irreversible condition of unconsciousness in which there is:
    - The absence of voluntary action or cognitive behavior of any kind.
    - An inability to communicate or interact purposefully with the environment

5 Wishes

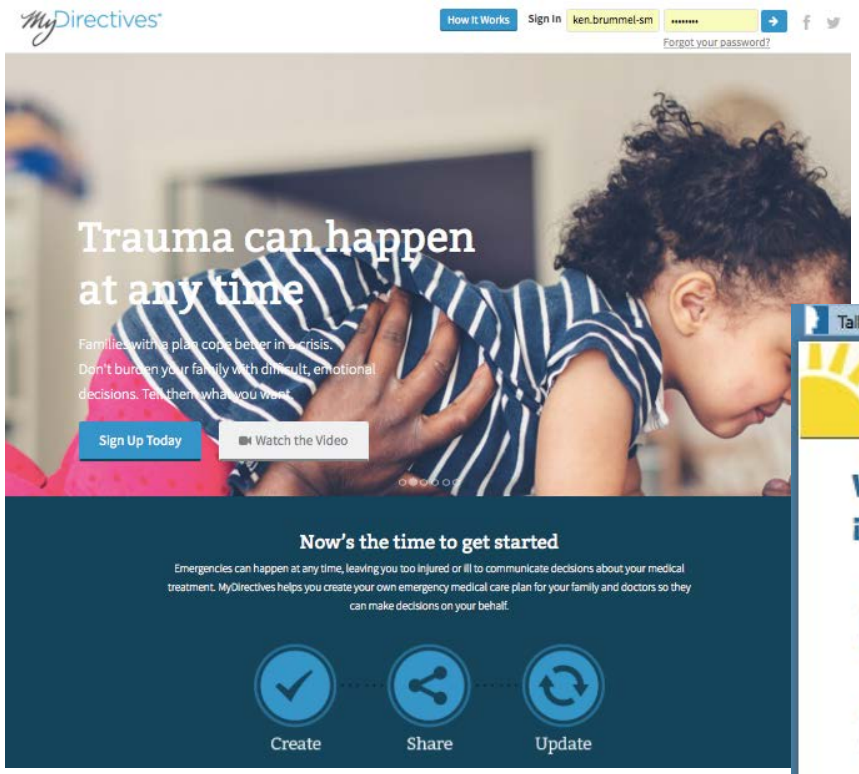
- Combines forms
  - Name a surrogate
  - Medical directives
  - Values history/end-of-life wishes
- Problems
  - Cost ($5)
  - Witness restrictions more strict than FL law
  - Medical directives vague

www.agingwithdignity.org 1-888-5WISHES (594-7437)

Advance Care Plan Document

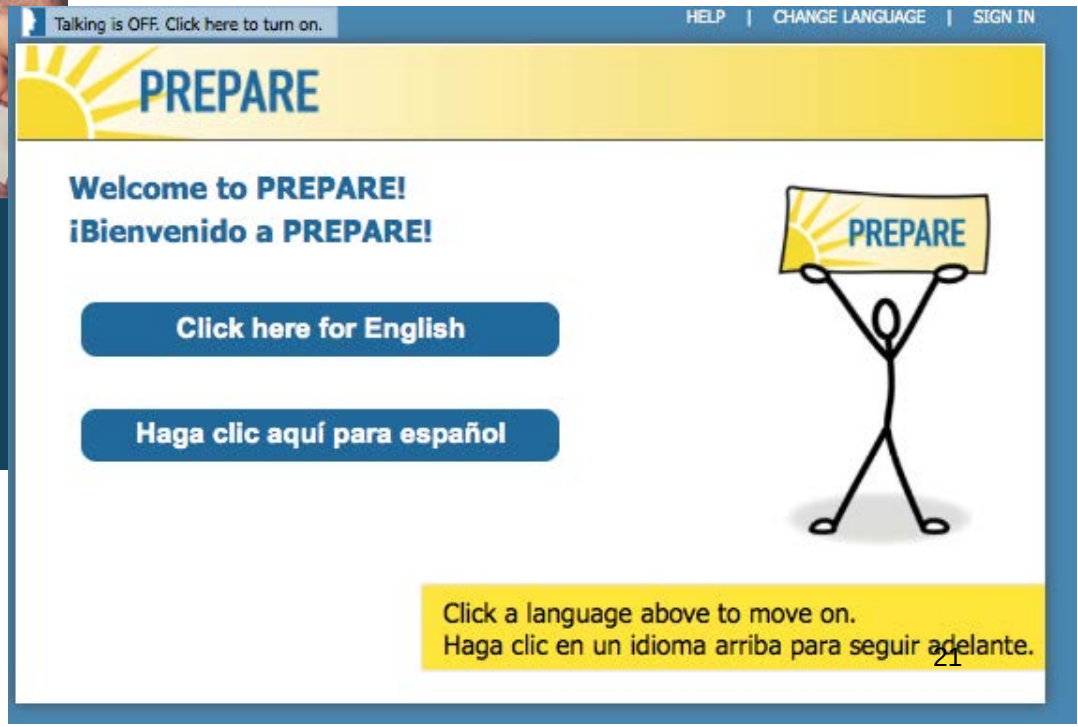
- Name a surrogate
- Specific choices on medical treatments
  - CPR
  - Life support
  - Surgery, antibiotics
  - “Tube feeding”
- Problems:
  - Vague terms
  - Only conditions listed

Online Advance Directives



MyDirectives.com

PrepareForYourCare.org



Limitations of Advance Directives

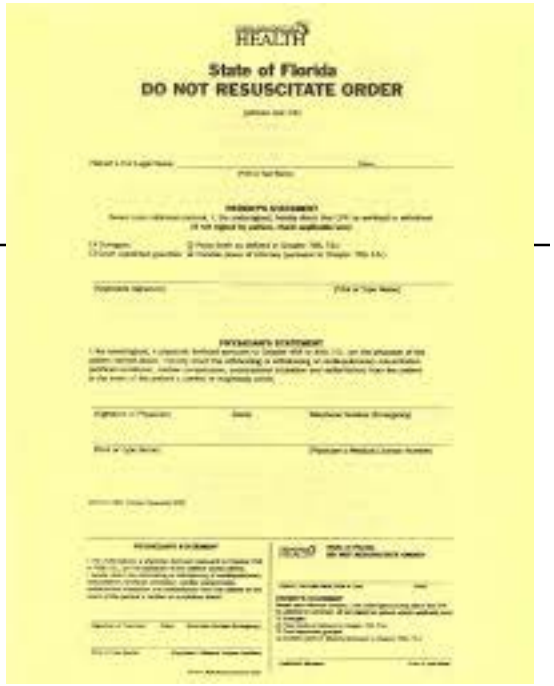
- Usually not available in clinical settings
- Do not provide clear guidance to EMS personnel
- Only 25% - 30% of people have them
- Variations in forms
- Terms may be unclear to clinicians
- Don't work well – SUPPORT study

Angela Fagerlin and Carl E. Schneider, "Enough: The Failure of the Living Will," *Hastings Center Report* 34, no. 2 (2004): 30-42.

Physician Orders

- Different than Advance Directives
  - In force NOW
  - Will direct the care provided by emergency personnel and other health care providers
- Should be limited to people with advanced life-limiting illness or advanced frailty

Physician Orders


HEALTH

State of Florida
DO NOT RESUSCITATE ORDER

- Do Not Resuscitate Order [1]
  - "DNRO form"
  - the "Yellow Form"
  - Used in FL
- Physician Orders for Life-Sustaining Treatment [2]
  - "POLST form"
  - the "Pink Form"
  - Used in 16 states, 30 more evaluating

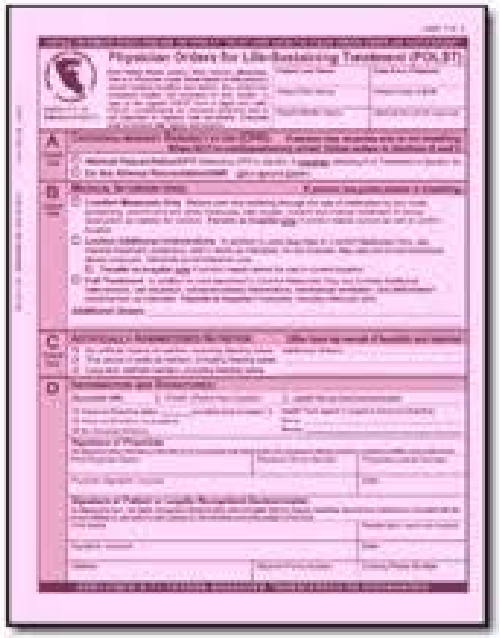
1- FL Statute 401.45, 2- www.polst.org

POLST is NOT an Advance Directive

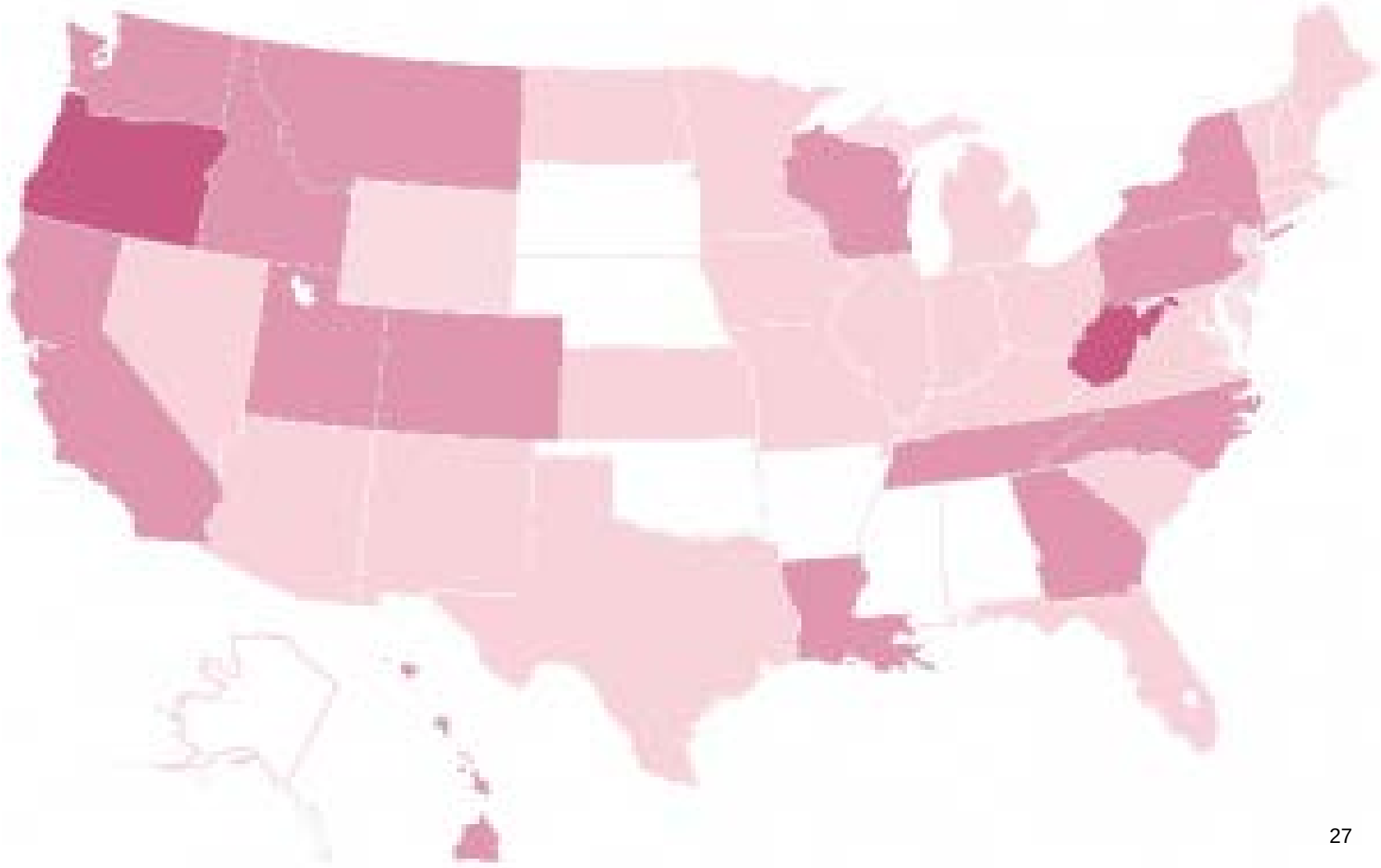
Advance Directive	POLST
Hypothetical / future condition	Current condition
Instructions to use as guide for decision-making	Actionable orders integrated in care plan
Created by patients	Created by physicians and health professionals

Purpose of POLST

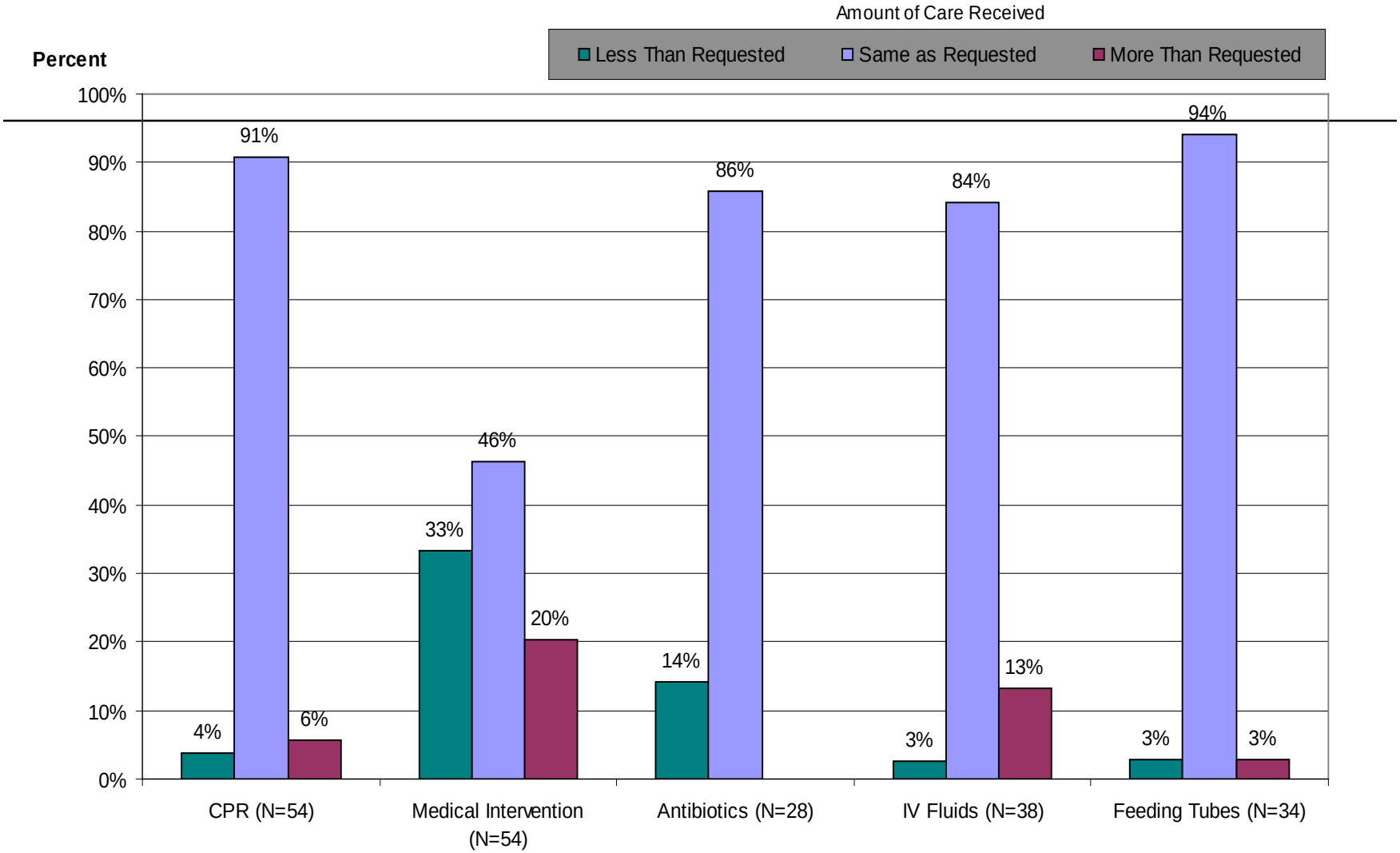
- To ensure that patient preferences are followed
- To provide a mechanism to communicate patient preferences for end of life treatment <u>across treatment settings</u>
  - Home ⇔ Hospital ⇔ Nursing home



POLST in the US



Percentage of Participants Who Received Less, Same, or More Care than Requested[1].



[1] *Percentages exclude participants for whom care was not applicable.*

Lee, Brummel-Smith, Meyer, Drew, London. *J Am Geriatr Soc*, 2000; 48:1219

POLST Categories

- Section A: Resuscitation or DNR
- Section B: Level of medical intervention
- Section C: Artificial nutrition
- Section D: Hospice or palliative care
- Section E: Signatures

Section A: Resuscitation

- Resuscitate (CPR)
  - Can't be "Comfort Measures Only"
- Do Not Attempt Resuscitate (DNR)
  - Have to have no pulse and/or no breathing
  - Some have suggested changing this term to "AND" – Allow Natural Death but EMS are not ready for that change yet

Section B – Three Levels

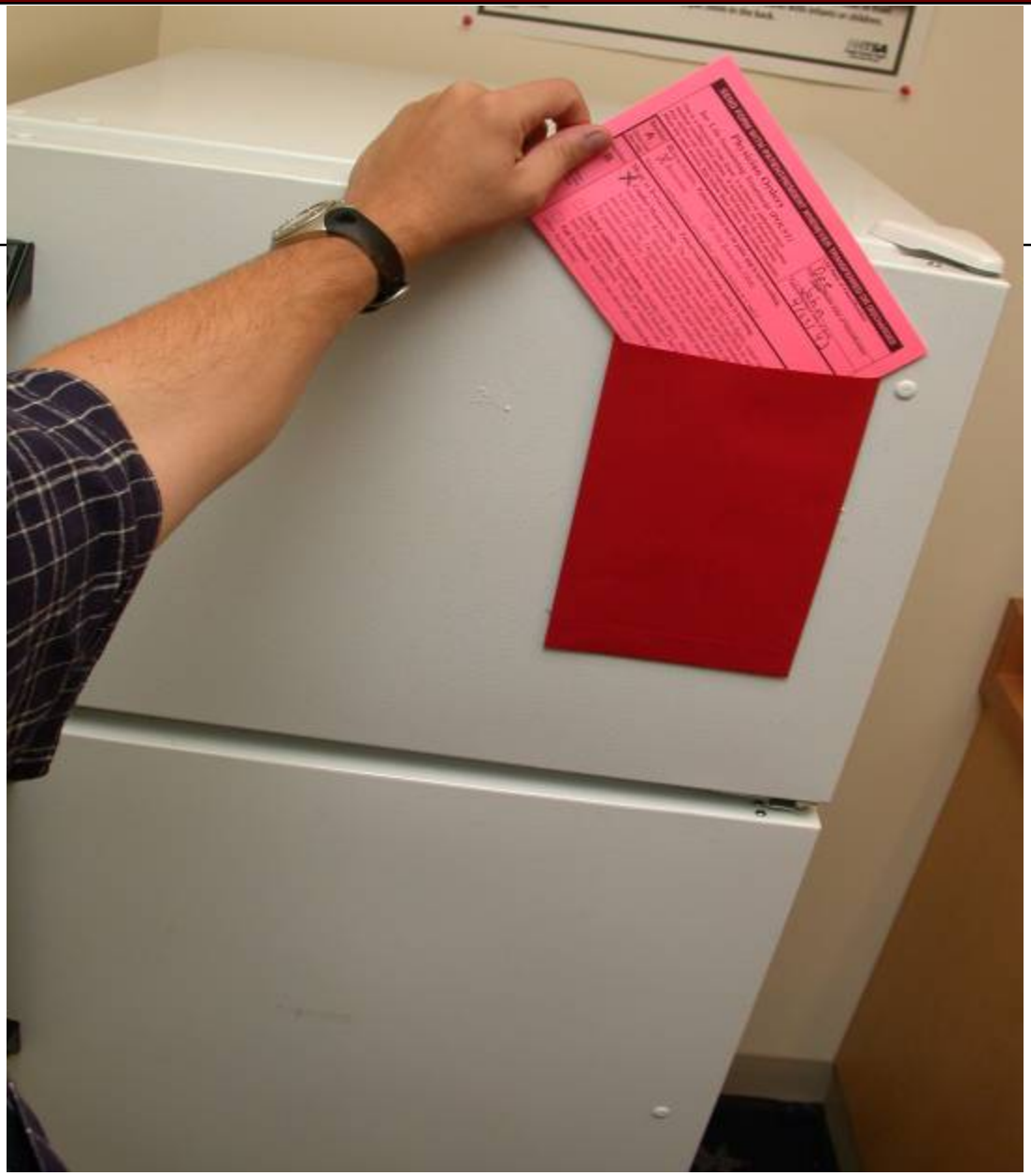
- Comfort Measures Only
  - Allow natural death
  - Transfer to hospital only if comfort needs cannot be met
  - Can’t be CPR
- Limited Additional Interventions
  - Do not use intubation or artificial ventilation, avoid ICU
- Full Treatment
  - Use intubation & ventilation, pacemaker insertion, ICU
  - Can be DNR

Sections C and D

- Artificial nutrition
  - No artificial nutrition by tube
  - Use for a defined trial period
  - Use long term
- Hospice and palliative care
  - Hospice?
  - Palliative care?
  - Not indicated or requested

Section E

- Physician signature
- Patient (or representative) signature



Resources

- www.empathchoicesforcare.org
- mydirectives.com
- www.prepareforyourcare.org
- www.polst.org
- med.fsu.edu/?page=innovativeCollaboration.POLST

GWEP Plan with HCN

- Training of nursing, providers, psychologists
- Use of ACP Decisions videos
- Incorporation of advance directives into EMR
- Use of advance directives as a quality measure