Advance Care Planning: Becoming Proactive

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Inside every older person is a younger person saying,

“What the hell happened!”

Patient as Healthcare Decision-Maker

Patient Self-Determination Act 1990

- Right to be fully informed to make autonomous decisions
- Right to refuse any medical treatment/procedure
- Right to execute an Advance directive
- Rights of proxies, surrogates, and family members

Potential Healthcare Decision-Makers

- Patient with capacity
- Orally designated surrogate
- Agent under advance healthcare directive
- Conservator or other court-appointed person
- Closest available relative

Unnamed Healthcare Decision-Makers

- If a person lacks the capacity to make decisions, the physician and health care team will usually turn to the most appropriate decision-maker from close family or friends of the person.
  - Most appropriate decision-maker- the person who has a close, caring relationship with the patient, is aware of the patient's values and beliefs, and is willing and able to make the needed decisions.
  - No next-of-kin hierarchy in CA
- What if the physician believes that the available decision-maker is not the most appropriate decision-maker or does not have the patient's best interests in mind?
- Unrepresented Patients who lack capacity

2007 CA study showed that 16% of ICU patients were unrepresented and 5.5% ICU patients who died were unrepresented.

More and more NODA programs established at hospitals

Unrepresented Patients: Reasons for Increase

- In the past these patients were homeless, drug addicted, mentally ill, or estranged.
- Now baby boomers with higher rates of childlessness and divorce have increased rate of unrepresented patients
- Smaller, more mobile families, and longer life spans
- Rates increasing as dementia rates increase
- Outlived all relatives; no friends
- Probably correlation between low advance directive rates and high rates of unrepresented patients

- Some states are adding “close friend” to the list of those who can consent to procedures
- In CA if a friend is not named by patient upon admission, the friend can only provide input, but can not make decisions
- In TX a member of the clergy can consent
- Implied consent in emergencies
- Healthcare decision-making teams

Preventive Steps

- Enlist friends or more distant relatives as surrogates
- Lawyers, geriatric care managers or professional guardians
- Explain beliefs and wishes to these surrogates and document preferences in detailed advance directives

Advance Care Planning Group Statement May 20, 2014

- A coalition* of Los Angeles-area healthcare providers endorsed guidelines intended to assist healthcare professionals and community individuals with advance care planning, end-of-life decision-making, and access to palliative care.
- The main goal of the guidelines is to respect individual values and reduce unnecessary suffering at the end of life.
- It is also hoped that physicians will feel more comfortable having end-of-life conversations and making difficult treatment decisions because they will feel the support of major LA-area healthcare providers and institutions that have formally endorsed the guidelines.

*Coalition participants include Cedars-Sinai Medical Center, HealthCare Partners Medical Group and Affiliated Physicians, Kaiser Permanente Southern California, Keck Medical Center of USC, Los Angeles Co-USC Medical Center, Huntington Hospital, Memorial Care Health System, Olive View-UCLA Medical Center, Providence Little Company of Mary Medical Center Torrance, Providence Trinity Care Hospice and the UCLA Health System.

Advance Care Planning L.A. County Guidelines

- Stresses the importance of advance care planning discussions and early access to palliative and other supportive services.
- Recommends that physicians have discussions with patients and families about the burdens and benefits associated with specific aggressive treatments and whether or not such treatments “may deprive the person of life closure.”
- Recommends that, when physicians believe treatment to be medically ineffective or non-beneficial, there should be a hospital process that defines how potential conflicts are addressed between patients/families and physicians and supports the idea that physicians are not obligated to provide such medically ineffective or non-beneficial treatment.

Goals of Advance Care Planning (ACP)

- Individuals & families are prepared for future decisions
- Choices in care reflect the goals and wishes of the patient
- Healthcare providers can be aware of the patient’s wishes

Overview of Forms & Terms

- Advance Health Care Directive
  - This form legally appoints Health Care Agent
  - It may indicate care preferences
  - Standard CA form
  - Five Wishes form
- Living Will (older document, not legally binding in CA)
  - Indicates preferences in care
- POLST - Physician Order for Life-Sustaining Treatment
  - Indicates treatment to be given or withheld per patient preferences

POLST

Physician
Orders for
Life
Sustaining
Treatment

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

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2011)

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. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If person has no pulse and is not breathing.*

When NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (**A**llow **N**atural **D**eath)

B — MEDICAL INTERVENTIONS: *If person has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. 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.*

☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. ***Transfer to hospital*** *if indicated. Includes intensive care.*

Additional Orders: _____

_____

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

Check One

☐ No artificial means of nutrition, including feeding tubes.

☐ Trial period of artificial nutrition, including feeding tubes.

☐ Long-term artificial nutrition, including feeding tubes.

Additional Orders: _____

_____

_____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____ available and reviewed →

☐ Advance Directive not available

☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

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:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

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.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Address:	Daytime Phone Number:	Evening Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

What is POLST?

- A physician order recognized throughout the medical system.
- Portable document that transfers with the patient.
- Brightly colored, standardized form for entire state of CA.

What is POLST?

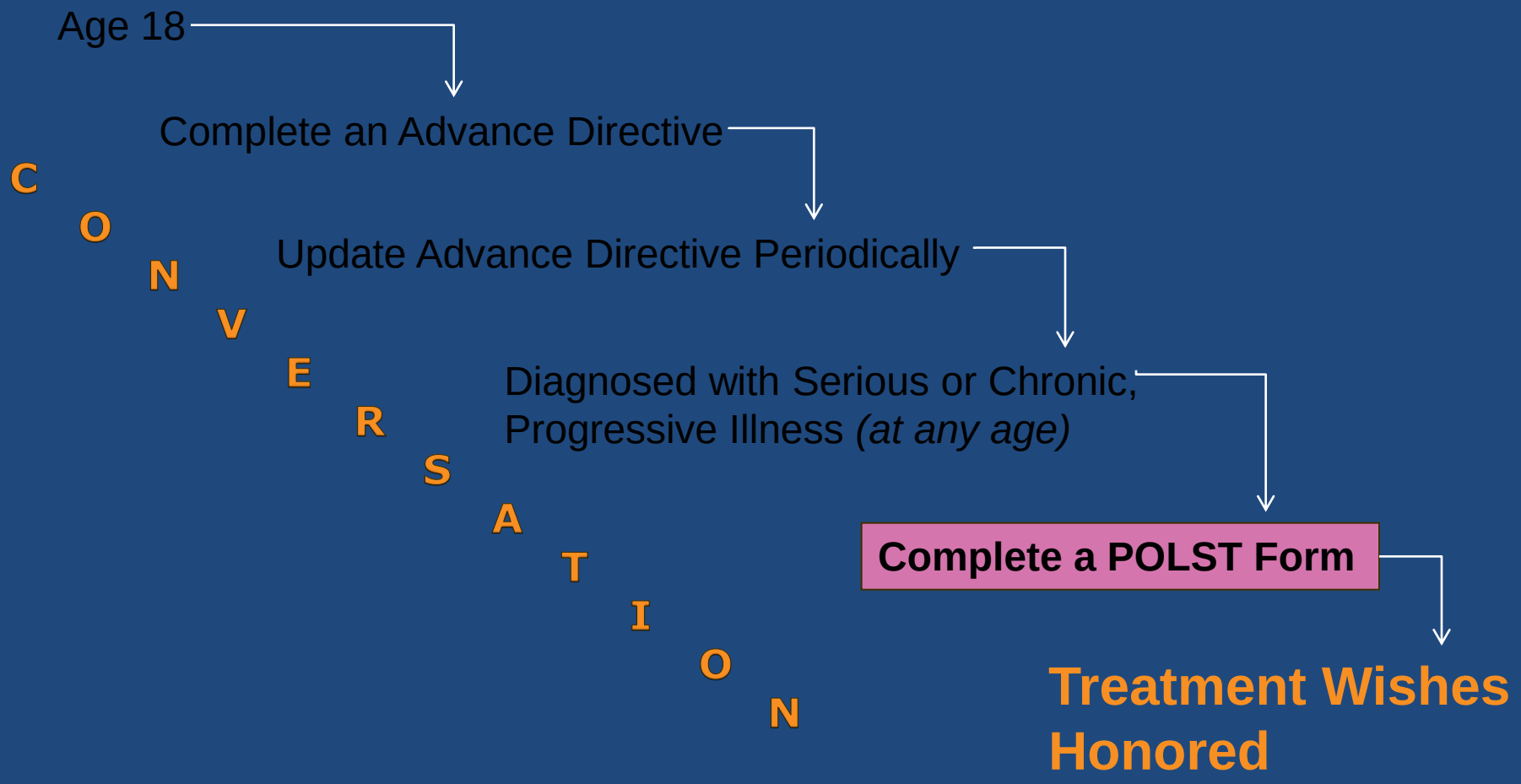
- Allows individuals to choose medical treatments they want to receive, and identify those they do not want.
- Provides direction for healthcare providers during serious illness.

Who Needs POLST?

- Chronic, progressive illness
- Serious health condition
- Medically frail
- Tool for determination
  - "You wouldn't be surprised if this patient died within the next year."

ACP Across the Continuum

Advance Care Planning Continuum



ACP: Starting the Process

All adults should begin ACP

1. Talk with family about wishes and goals
2. Choose an Agent and complete an advance directive

Leading causes of death in patients aged 18-45 should prompt a discussion about what they might want in case of severe brain injury.

4 Step Process

1. Choose a medical decision-maker
2. Decide what matters most in life
3. Ask doctors the right questions
4. Tell others about your wishes, including your doctor

Step 1
Choose a Medical decision-maker

- Why Choose a Medical decision-maker
  - Because of accidents or illness, 3 out of 4 people will be unable to make some or all of their own medical decisions at the end of life.
  - If this happens, doctors need to know who can make decisions for you.
- A medical decision-maker is someone who can make medical decisions for you ONLY IF you are too sick to make your own decisions.
- But, you can ask this person to start making decisions for you whenever you want, even now.

Qualities of a Decision-Maker

- Willing and able to be your Agent
- Knows your values and preferences
- Can make difficult decisions (under stress)

A medical decision-maker can be:

- A family member or friend
- A group of people with ONE person who will speak to the doctors for the group

If you are unable to make your own decisions, your decision-maker may need to:

- talk to your doctors and say yes or no to medical treatments for you
- decide where you get medical care, such as a nursing home or hospital

How to Ask Someone to Be Your decision-maker

- Do not assume someone will know that you want them to be your medical decision-maker. You have to ask them.
- Tips:
  - Choose a quiet place and time to bring it up.
  - Make sure the person understands what you are asking them to do.
  - If the person feels uneasy, you may want to give them time to think about it, and ask them again later.
  - Some people may say no. If so, you may need to think of someone else

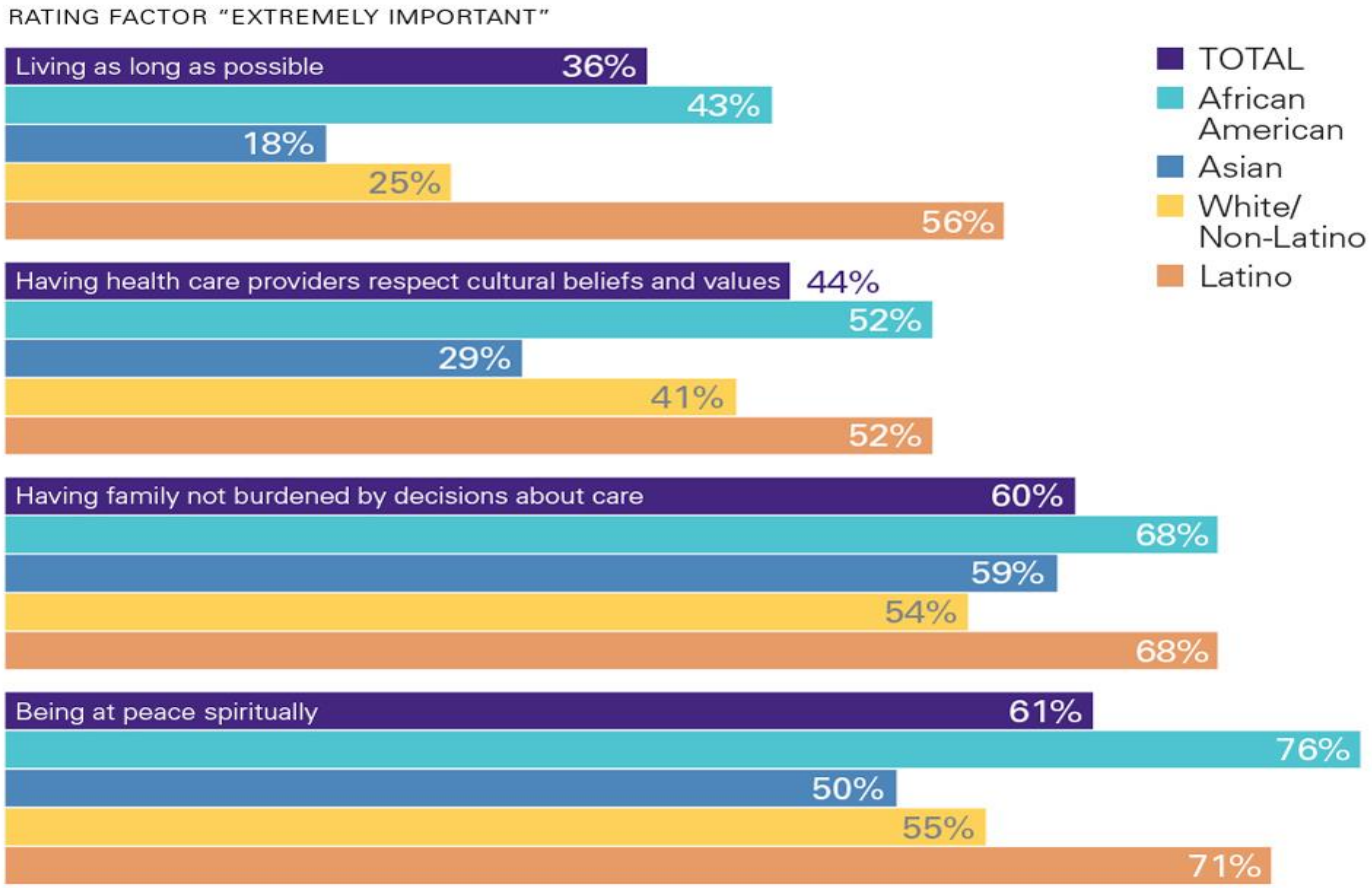
Scope of the Decision-Maker's Authority

- Choose healthcare providers
- Agree to testing
- Approve or refuse medical treatments
- Post death:
  - Funeral arrangements (California Cemetery Law, Article 7100- the person who has the valid DPOAHC in California has the responsibility and/or right to make funeral arrangements. Per Health and Safety Code Section 7100-7117.1. this authority trumps that of a spouse, legal partnership, children, etc. More info re: this can be found under the Department of Consumer Affairs Cemetery and Funeral Bureau).
  - Donate organs
  - Authorize autopsy
  - Review medical records

Step 2
Decide What Matters Most in Life

Deciding what matters most in your life can help you get the medical care that is right for you

Most Important Factors at End of Life,
by Race/Ethnicity, California, 2011



Source: Californians' Attitudes Toward End-of-Life Issues, Lake Research Partners, 2011. Statewide survey of 1,669 adult Californians, including 393 respondents who have lost a loved one in the past 12 months.

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How to Decide What Matters Most in Life:

1. What is most important in your life? Family? Living on your own?
2. What experiences have you had with serious illness or death?
3. Can you imagine health experiences worse than death?
4. Is it most important to you to:
    - Try to live as long as possible, even with pain or disability?
    - Try treatments for a period of time, but stop if you are suffering?
    - Or focus on quality of life and comfort, even if your life is shorter?
5. Have you changed your mind about what matters most in life over time?

Step 3
Ask Doctors the Right Questions

- You or your decision-maker can ask about:
  - Benefits - the good things that could happen from treatment
  - Risks - the bad things that could happen from treatment
  - Your other options for different kinds of treatment
  - What your life will be like after starting treatment

Step 4
Tell Others About Your Wishes

- Tell your decision-maker and doctors about what is most important to you in life and about your wishes for medical care.
- Tell your doctors who your decision-maker is and how much flexibility you want to give them.
- Tell your close family and friends about your wishes, who your decision-maker is, and how much flexibility you want to give them. This may help prevent conflict.
- Your doctors can help you fill out an advance directive form and put the name of your decision-maker and your medical wishes into your chart.

ACP: When to Revisit

- Refresh your conversation and your documents:
  - New medical condition or scheduled surgery,
  - Change in family circumstances: Marriage, divorce, death, child turns 18,
  - Relocation,
  - New providers,
  - Every 5 years.

Resources

- http://ag.ca.gov/consumers/pdf/AHCDS1.pdf
-
- http://coalitionccc.org

Questions?