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ADVANCE CARE PLANNING
WHERE ARE WE AND HOW TO BEST DO
OBJECTIVES

- Define advance care planning
- Discuss impact on care
- What should be part of ACP and when should it happen
- Tools to use for providing medical care to the elderly
Ms. DK

- 88 yo female, sent to ER from an ALF for new onset stroke
Ms. DK

Other history
- Dementia
- Stroke in past
- Wheel chair bound
- Had been on hospice in the past
- POLST available
- Daughter at bedside
- Pleasant but speaks in word salad
TPA protocol began, includes blood work, emergency CT scan, cardiac monitoring

Neurology alerted by ER per protocol

Daughter calls primary care provider for advice
Primary care MD speaks to neurology and comes to the ER
Nurses upset when told to not continue stroke protocol
POLST at patient’s bedside
ER doctor informed of patient’s functional status which he stated he did not know what her functional status was prior to “stroke”
History of Advance Care Planning

- 1960s – DNR, no choice
- 1983 – Nancy Cruzan, Supreme Court definition of ADs, Artificial N and H
- 1990 – PSDA
- 1990s – POLST paradigm started
- 1996 – how we die in america
- 2006 – how we die in america
What we’ve learned

- A lot
- It’s about the conversation
- It’s not about DNR
- How to have to conversations – tools available
However, What we still need to learn

- Providers
  - Limited training
  - “limited time”
  - Poor documentation and review
  - Conversations remain limited to DNAR
  - Lack of understanding value
Still learning

- Electronic medical record
  - Where is it?
  - How should it be labeled
  - What is the best documentation process, can be cumbersome
Still learning

- Organizations
  - Multiple priorities
  - Understanding the importance
- Communities
  - Confusion about the process
  - Best document?
  - Lawyers
Number of people age 65 and over, by age group, selected years 1900-2000 and projected 2010-2050

Note: Data for 2010-2050 are projections of the population.
Reference population: These data refer to the resident population.
Source: U.S. Census Bureau, Decennial Census and Projections.
DIFFERENT GOALS OF THERAPY

medications and therapies
increased rates of adverse effects to
increased importance of social support
illnesses

Atypical presentation of common
under-reporting of symptoms
interacting, diseases

Tendency to have multiple, often
increased prevalence of disease
physiologic changes
heterogeneity of health status

PATIENTS

WHAT’S DIFFERENT ABOUT OLDER
“I’m going to send you to someone who’s not afraid of doing a little harm.”
Who should have an ACP

- Any one over the age 18!!
- Really?
- Certainly over the age of 65
- Seriously ill – ACP and POLST
Models – pick one for ACP

- Prepareforyourcare.org
  - Choose a medical decision maker
  - Decide what matters most in life – 5 questions
    - What is most important in your life
    - What experiences have you had with serious illness or death
    - What brings you quality of life
    - If you were very sick, what would be most important to you
    - Have you changed your mind about what matters
Prepare for your care (cont)

- Choose flexibility for your decision maker
- Tell others about your medical wishes
- Ask doctors the right questions
  - Benefits
  - Risks
  - Other options
  - What would your life be like after treatment
- Then do a document
Models for conversation

- The Conversation Project
- Similar to Prepare
- Gives specific phrasing for talking to family
- Theconversationproject.org
Review of document – crucial

- Decision maker
- Decisions
- Any changes
- Consistency of decisions
- Signatures in place
- Done yearly or with change of condition
Conversations about serious illness – when to have them

- The Surprise Question
  - Would you be surprised if patient died in the next year? Surprisingly predictive
- Multiple hospitalizations
- New life threatening diagnosis
- There are multiple models for this
SPIKES – 6 steps

- S – setting up the interview – what, where, who, intros
- P – patients perception
- I – invitation, what does the patient want to know
- K – giving knowledge and info to patient
- E – addressing emotion
- S – strategy and summary
Serious illness conversation guide

- Set up the conversation
- Assess understanding a preferences
- Share prognosis
- Explore key topics – goals, fears, worries, sources of strength, abilities tradeoffs, family
- Close the conversation – summarize, make a recommendation, check in with patient, affirm commitment
- Document
# POLST vs Advance Directive

<table>
<thead>
<tr>
<th>Type of document</th>
<th>Medical order - POLST</th>
<th>Legal document, goals - AD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who completes</td>
<td>Provider and patient or surrogate</td>
<td>Individual</td>
</tr>
<tr>
<td>Who needs one</td>
<td>Seriously ill or frail, surprise question</td>
<td>All competent adults</td>
</tr>
<tr>
<td>Appoints a surrogate</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>What is communicated</td>
<td>Specific medical orders</td>
<td>General wishes about treatment, a guide</td>
</tr>
<tr>
<td>Can EMS use</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ease in locating</td>
<td>Easy to find, in chart, patient has original</td>
<td>Depends</td>
</tr>
<tr>
<td>Signatures</td>
<td>Provider, patient or SDM</td>
<td>Varies from state to state</td>
</tr>
</tbody>
</table>
POLST – the seven deadly sins

- Using the POLST with people who are too healthy
- Signing a POLST without meaningful discussion with patient and SDM
- Having patients complete their own POLST form
- Providing incentives for completing more POLST forms
Seven sins continued

- Failing to review POLST forms
- Letting POLST disappear
- Failing to evaluate your use of the POLST paradigm
WHAT MATTERS TO THE PATIENT IS AS IMPORTANT AS WHAT IS THE MATTER WITH THE PATIENT

It is about the conversation

But it is also about a commitment from all involved