The Next Generation of Advance Directives

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Riverside Health System
Need for a Better System

• Only 25% of all adults have Advance Directives
• 70% of people wish to die at home
  • 53% die in hospitals
  • 24% die in nursing homes
  ▫ 35% of hospice patients have LOS fewer than 7 days.

American Medical News 2/1/12
Center to Advance Palliative Care
Medicare Beneficiaries deaths in hospital

- National Average
- Virginia Average
- NN HRR
- Richmond HRR
- Norfolk HRR
- Milwaukee
- LaCrosse
- National 90th/10th percentile
Medicare cancer patients, number of hospice days last month of life

- National Average
- Virginia Average
- NN HRR
- Richmond HRR
- Norfolk HRR
- Milwaukee
- LaCrosse
- National 90th/10th percentile
Why Haven’t Advance Directives Worked?

- Often completed without guidance
- Written years in advance
- Can’t be found
- Contingent on a ‘terminal’ condition
- Most decisions must be made before someone is in a terminal condition
The Town Where Everyone Talks About Death
by Chana Joffe-Walt, NPR
March 05, 2014 5:00 AM ET
Respecting Choices® Model of Advance Care Planning

Gundersen Lutheran Medical Center, LaCrosse, WI

• Prevalence of Advance Directives
  ▫ 83% of Adults in LaCrosse

• Patient/family satisfaction:
  ▫ 93% Very Satisfied
  ▫ 65% in control group

• Hospital Code Blue Survival to Discharge
  ▫ National 19%
  ▫ Gundersen Lutheran 33%
• Depression scores in bereaved families (Scale 1-9)
  • Participated in ACP = 1
  • No ACP = 5
  • *Impact of Event* study found those who had not participated in ACP had stress levels in the PTSD range
“It’s about How You Live”

- Facilitating Advance Care Planning...was associated with end-of-life care at home. Use of hospice services was common following ACP.  
  \[J \text{Am Geriatr Soc 49:778–781, 2001}\]

- Cancer patients in hospice care found to live 29 days longer than those who did not receive hospice services.  
  \[Journal of Pain & Symptom Management, March 2007\]
Secret to Success: Establishing Community-Wide Systems of Care

- Public is informed and engaged
- Patients are informed about their condition and options for treatment
- Health care providers have processes in place to understand and honor patient choices
Advance Care Planning Coalition of Eastern Virginia
Advance Care Planning

A process of communication throughout the adult lifespan, focused on values and with expert guidance
It’s about the...
Conversations that change over time

Healthy Adults: Planning for the Unexpected

People with Progressive Illness: guided planning

End Stage Illness: Convert preferences into physician orders
Healthy Adults

- Name a Healthcare Agent
- Prepare for sudden injury or event
- Write a basic Advance Directive
Progressive Illness

- Understand potential complications and treatment options
- Consider benefits and burdens of end of life treatments
- Discuss preferences, hopes and fears with family
- Make Advance Directive more specific
- Re-evaluate goals with changes in condition
Late Stage Illness

- No longer hypothetical
- Express preferences for treatment as medical orders
- Use POST form in communities where it is accepted
POST (Physician Orders for Scope of Treatment)

<table>
<thead>
<tr>
<th>Virginia Physician Orders for Scope of Treatment (POST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
</tbody>
</table>

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
- [ ] Attempt Resuscitation
- [ ] Do Not Attempt Resuscitation (DNR/No CPR)
  - When Do Not Attempt Resuscitation is checked, qualified healthcare personnel are authorized to honor this order as if it were a Do Not Resuscitate order.

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

MEDICAL INTERVENTIONS: Patient has pulse and 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 Instructions” 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, IV fluids and cardiac monitoring as indicated. (Hospital transfer if indicated. Avoid intensive care unit.) Also see “Other Instructions” if indicated below.
- Full interventions: In addition to Comfort Measures above, use intubation, mechanical ventilation, cardiovascular as indicated.
  - Transfer to hospital if indicated. Include intensive care unit. Also see “Other Instructions” if indicated below.

Other Instructions:
- 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 Instructions:
- DISCUSSED WITH:
  - [ ] Patient
  - [ ] Agent under Advance Medical Directive
  - [ ] Court-appointed guardian
  - [ ] Other person legally authorized

Physician: 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.

Physician Name (Print) (Mandatory) | Physician Phone (Mandatory)

Physician Signature (Mandatory) | Date (Mandatory)

Signature of the Patient OR the Person Legally Authorized to Consent on Patient's behalf (Mandatory)

Patient’s Signature | Name of Person Signing for Patient (Print)

Address

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED
Advance Care Planning

Four steps to a good plan
Step 1: Choose a Healthcare Agent

- Understands your values
- Will honor your choices
  - Even if they disagree
- Will be available, and able to talk with the medical team
Step 2: Talk about it!

“Family members predict patient preferences for about half of the experiences that patients have identified as important to them at the end of life.”

Getting Started

• News Stories
  ▫ Terri Schiavo
  ▫ Hugh Finn
  ▫ Nancy Cruzan
  ▫ Karen Quinlan

• Recall family and friends’ experiences
  ▫ What would you want in a similar situation?
Step 3:
Learn what decisions may lie ahead, and what you want from your medical treatment plan
Do you understand your illness?

• What are the possible complications?
• What are your goals for treatment?
• Do you have any fears about treatment?

Make a list of questions for your doctor.
Questions for Your Doctor

• What complications could happen with my illness?
• What are the options for treating those complications?
• What are the likely results of those treatments, for me?
• What risks should I be aware of?
• Will those treatments help me to ________________?
• What if I decide against those treatments? What else can be done?
Talk about what is important to you

- What does it mean to Live Well?
- What gives your life meaning?
- Are spiritual or cultural values important?
Are you speaking in code?

• “I don’t want to be a burden.”
• “Don’t give up on me.”
• “I don’t want any machines.”
• “I want everything.”
“Life Prolonging Treatments”

- Cardiopulmonary Resuscitation
  - After the heart and breathing have stopped
  - Includes ventilator
- Ventilator ("Breathing Machine")
- Artificial Nutrition
- Dialysis
- Antibiotics
- Artificial Hydration
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Would you want life prolonging treatment if...

Healthy Adults
- Sudden Accident or Injury
- Sudden Illness

- If you did not know yourself and could not recognize your family
- Would you want life-prolonging treatment?
- Is there a fate that is “worse than death” for you?
Would you want life prolonging treatment if...

- If there were a complication and you were not expected to recover...
- What would be your goals for treatment?
- What is your doctor’s advice for reaching those goals?

People with Progressive Illness

- Complications
  - Stroke
  - Heart Attack
  - Respiratory Distress
Would you want life prolonging treatment if...

- Near the end of life...
- What are the patient’s goals for treatment?
- Can the goals be reached with life-prolonging treatments?
- What treatments are available to provide comfort?

People with end-stage illness

- Last phase of the illness
  - Cardiac arrest
  - Respiratory Distress
  - Inability to eat or drink
Begin with the goal.

*If a complication happened, would the recommended treatment help you reach your goal?*
Step 4. Write It Down

• Advance Directive
  ▫ Activated when ________________
  ▫ Names the ____________________
  ▫ End-of-Life instructions honored when ________________
  ▫ Give it to _____________________
  ▫ Talk about it with ___________________
• Mental Health Advance Directives
  ▫ Protect a person against their future irrational decisions
  ▫ Can allow a Healthcare Agent to retain their role over a later protest
  ▫ Require a physician signature
Where to Get Advance Directives

- Riverside
- Sentara
- www.Caringinfo.org
- Five Wishes
FAQs

• Decisional Capacity
• Legally authorized decision makers
• Notary not required
• Attorney not required
• Not an “Emergency” plan
  ▫ Different from a DNR order
Mrs. Young

- 78 years old
- Major stroke
- CPR started in the ambulance, intubated en route
- Worsened in ICU
- Doctor advised that she was unlikely to regain consciousness
Mrs. Young’s Family

- Differing opinions about continued treatment
- Had never talked about when or if she would have wanted treatment stopped
- Family felt like making a decision to stop treatment was ‘causing’ her death
Mrs. Young’s Advance Directive

• Her son found her Advance Directive in her dresser at home
• The AD stated that she would not want to be kept alive by artificial means if she was unlikely to recover well enough to remain living at home
• The family asked the doctor to remove the machines and allow her a natural death
• Mrs. Young died peacefully 4 hours after, with her family together at her side
What Would Scooby Do?
Questions?