KATHRYN BORGENICHT, M.D. FACP, HMDC

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

DK

- TPA protocol began, includes blood work, emergency CT scan, cardiac monitoring
- Neurology alerted by ER per protocol
- Daughter calls primary care provider for advice

DK

- 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

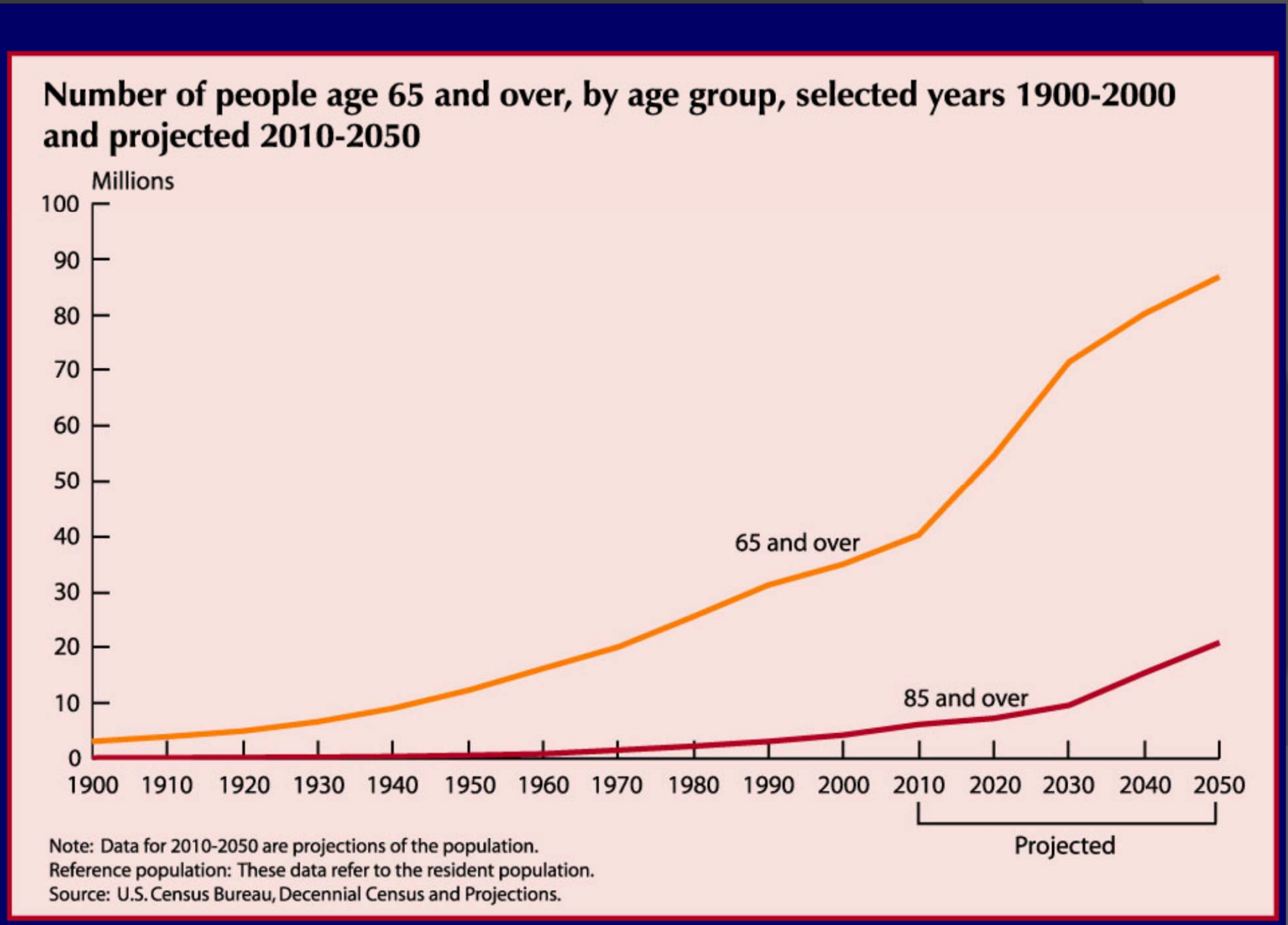
- Providers
  - Limited training
  - “limited time”
  - Poor documentation and review
  - Conversations remain limited to DNAR
  - Lack of understanding value

Still learning

- Electronic medical record
  - Where is it?
  - How should it be labeled
  - What is the best documention 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
Millions
100
90
80
70
60
50
40
30
20
10
0
65 and over
85 and over
1900
1910
1920
1930
1940
1950
1960
1970
1980
1990
2000
2010
2020
2030
2040
2050
Projected
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.

WHAT'S DIFFERENT ABOUT OLDER PATIENTS?

- Heterogeneity of health status
- Physiologic changes
- Increased prevalence of disease
- Tendency to have multiple, often interacting, diseases
- Under-reporting of symptoms
- Atypical presentation of common illnesses
- Increased importance of social support
- Increased rates of adverse effects to medications and therapies
- Different goals of therapy

"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

Prepareforyourcare (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

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

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