Advance Care Planning: How We Respect Your Values and Choices

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Learner Objectives

- Define and discuss Advance Care Planning.
- Identify the components of a “Good” Advance Directive.
- Identify the four criteria of a competent and effective DPOA-HC.
- Identify at least four skills for competent conversations regarding your goals of care with your physician and family members.

ACP – Definition

- Advance Care Planning
  - a process which assists individuals, family, friends and advocate(s) to:
  - understand, reflect upon, discuss and plan current and future care choices based upon the values of the patient
- An organized approach to initiating conversations, reflection and understanding regarding an individual's:
  - Current state of health, goals, values/preferences for healthcare treatments, at key intervals in the illness experience as well as at the end of life.

ACP: The Process

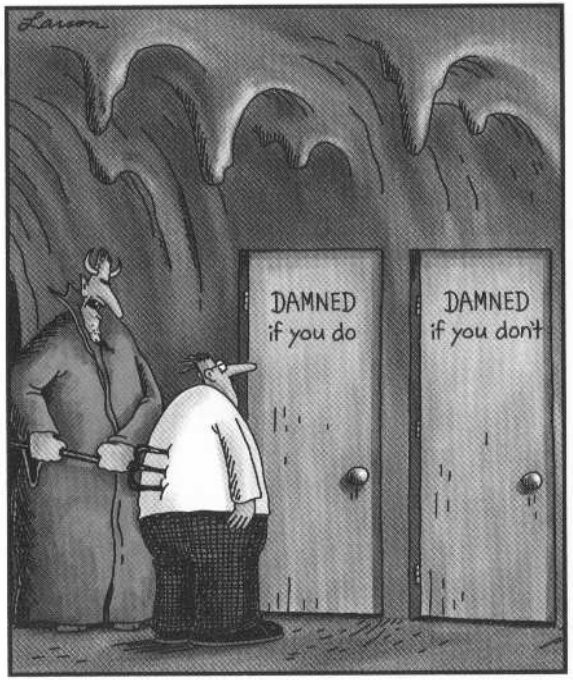
- *Benefits of ACP*:
- Enhances the patient-physician relationship:
  - Increase in patient belief that the physician cares about them
  - Increase in patient belief that the physician understands/values their preferences
- Enhances the quality of the conversations
- Enhances the commitment to having conversations with family and friends.

The ACP Process

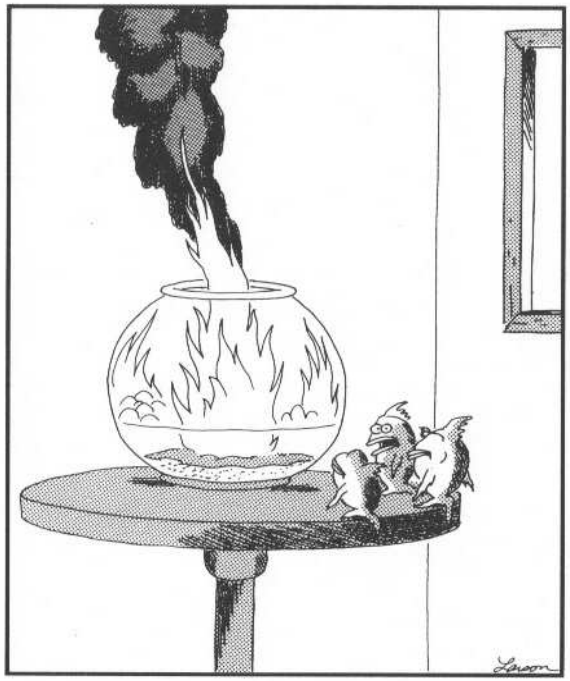
- Commit to the conversation.
- Clinicians: honor a person's choices, values, decisions.
- Individuals: articulate values and improve knowledge of HC status.
- Holistic focus: prognosis, pt concerns, experience of current illness, short and long-term goals, personal values.

ACP: The Process

- Shift from crisis mode to engaging in communication with the patient and family.
- Develop partnership.
- Identify pt values and choices.
- Build trust.
- Decrease anxiety/fear.



"C'mon, c'mon—it's either one or the other."



"Well, thank God we all made it out in time. …
'Course, now we're equally screwed."

ACP: The Process

- Discuss choices, values and treatment approaches with:
  - Family members
  - DPOA-HC
  - Your physician
  - Friends
  - Clergy or Spiritual Advisor
- Gives moral direction and emotional comfort to family.

ACP: The Process

- Affirm your relationship with the patient.
- Schedule adequate time.
- These discussions are a part of good primary care.
- Initial goal: explore issues, understand their preferences, and answer questions.
- Affirm the importance of palliative care

Components for Successful ACP

- Gain understanding and clarification of your medical conditions from your physician.
- Clarification of your treatment choices at significant junctures in your illness with your family and physician.
- Discussion of common scenarios of the natural history of your chronic illness - - its progression over time
- Discussion of common scenarios of how people die from your chronic illness.

Components for Successful ACP

- Identify the person (s) in your life with the following skills:
  - Perform well under stressful conditions
  - Articulate
  - Comfortable in hospital settings – E.D., ICU's, etc
  - Not intimidated by physicians
  - Their emotions will not inappropriately interfere with critical decision-making moments in your care.

Components for Successful ACP

- Have *EARLY CONVERSATIONS* WITH:
  - Physician
  - Family
  - Friends
  - Your surrogate
- Have your doctor share common scenarios
- Discuss your treatment choices with family, DPOA-HC and your physician.

Successful ACP

- Future options are understood
- Options are considered in light of the person's values and goals
- Choices are discussed
- A plan is formulated and supported
- Surrogates and loved ones accept that following the plan is a loving act

Maryland ACP Highlights

- Health Care Planning thru the Adv Directive.
- Name a HC Agent.
- State your preferences for treatments, including txs that might sustain your life.
- Meant to reflect your preferences.
- You decide when you want your HC Agent to speak for you – now or when you have lost capacity for decision-making.

Maryland ACP Highlights

- Living Will and LST procedures
- Standardized Order form: Emergency Medical Services Palliative Care/Do Not Resuscitate Order Form.
  - Must also have this order signed by doctor
  - EMS will then honor this order
- Preference in Case of Terminal Condition

Maryland ACP Highlights

- Maryland Handbook for HC Surrogates or DPOA's:
  - Make decisions based on patient's values and prior choices
  - Make decisions consistent with statements in A.D.
  - CPR, Art Nut/Hyd, Respirators --- all in context of risks/benefits.

Living Will

- Follows “If … then …” model
  - “If I lose capacity and I’m in [specified conditions],
  - Then no CPR, ventilator, feeding tube, etc.”
  - Or: aggressive interventions requested
- Decision to forgo carried out if two physicians certify:
  - Terminal condition
  - End-stage condition
  - Persistent vegetative state

Terminal Condition

- Incurable
- No recovery even with life-sustaining treatment
- Death “imminent”
  - When’s “imminent”?
  - Up to doctors

End Stage Condition

- Progressive
- Irreversible
  - No effective treatment for underlying condition
- Advanced to the point of complete physical dependency
- Death not necessarily “imminent”
  - Primarily advanced dementia
  - CHF, COPD
  - Neurologic Conditions

Persistent Vegetative State

- No evidence of awareness
- Only reflex activity, conditioned response
- Wait “medically appropriate period of time” for diagnosis

Conversation Skills

- Understand your diagnosis, prognosis, lifestyle issues and goals.
- Know the natural history of your illness.
- Share your personal values, goals, religious beliefs or spiritual beliefs….
  - How do they inform your medical treatment choices?
- When you are well … at least choose an advocate.

Conversation Skills – Living with a Chronic Illness

- Initial conversations:
  - Explore attitudes, concerns
  - Discuss values and beliefs, answer questions or concerns

- "At this point, how can I help you live well?"

- Provide the patient with examples of how her particular disease is likely to progress.
  - Treatment decisions she is likely to face in the future
  - What situation would be worse than death?

Discussions – Chronic Illness

- Provide the patient with typical outcomes
- Offer treatment options and reasonable approaches
- Discuss personal and/or spiritual impact of decisions
- Discuss financial impact of decisions
- Offer opportunity to discuss with others with same illness.

ACP Discussion: New Serious Medical Problem

- Determine if the person is well enough and capable of having a conversation.
- Provide an opportunity to discuss their fears and concerns
- Goal of ACP: to know what you want and respect your choices
- Offer support, be open, supportive listening.

New and Serious Medical Illness

- Assess the patient's understanding of their medical condition.
- Provide an opportunity to discuss values, important beliefs, fears and concerns.
- Gain understanding of who the patient would choose as DPOA-HC
- If possible, include the DPOA-HC in current conversations.
- Determine what type of outcomes would be desirable and undesirable for the patient.

Known Terminal Illness

- Would you be surprised if this person were dead in 12 mos.?
- At this point, how can I help you continue to live well?
- Discuss the patient’s current perspective of her illness.
- Discuss the patient’s thoughts on current treatment(s).
- Discuss comfort care and treatment goals.

Terminal Illness

- Discuss issues related to resuscitation and other forms of life sustaining treatments.
- Discuss POLST orders.
- Have the patient share their most important goals - - - for family, friends, spiritual fulfillment, etc.
- Provide resources as needed to accomplish the goals of treatment and living with a sense of peace.

Summary

- Components of a well-planned A.D.
  - Personal reflection and thought
  - Discussions with physician
  - Discussions with family, friends, surrogate
  - Articulate your values and choices clearly
  - Articulate your choices for care at various points of living with your illness, including the last months of your life

Summary

- Skills of a “good” DPOA-HC
  - Articulate
  - Performs well under stressful conditions
  - Not intimidated by physicians
  - Emotions do not interfere with ability to articulate your choices/decisions

Summary

- Conversational skills
  - With family, friends
  - With your physician
  - With your surrogate, DPOA-HC
- ACP Facilitation Skills

Questions/Comments?