Updates in Advance Care Planning

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Disclosure

• I have no significant financial relationships to disclose.
My hopes for this hour

• Describe 2 new tools to engage vulnerable patients in advance care planning
• Apply motivational interviewing techniques to advance care planning
• Identify other potential clinic resources to enable more advance care planning
• Recognize key legislation impacting POLST completion in 2016
My hopes for this hour

GUILT
Outline

• Dialogue on barriers, challenges to completing advance care planning forms with patients
• Introduce different approaches to advance care planning, tools
• Prioritize patients who you want to engage in advance care planning, and identify next steps
• Update on changes to California POLST, when to complete one, and communication
What are we talking about?

California Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

- This form has 3 parts. It lets you:
  - Part 1: Choose a health care agent.
    - A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.
  - Part 2: Make your own health care choices.
    - This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.
  - Part 3: Sign the form.
    - It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.
Fill out only the parts you want.
Always sign the form in Part 3.

Go to the next page
Why do it, anyway?

• Changes what happens to patients at end of life
  – Less likely to receive aggressive care
  – Wishes more likely to be followed
  – May affect hospice enrollment

• Changes family members’ experience
Why it’s important for *our* patients

- Barriers that limit access to care also impact life expectancy
  - Homelessness
  - Substance abuse, mental illness
  - Legal concerns

- Timeline for discussion is often shortened

- Disparities exist
  - Advance care planning
  - Access to hospice
Barriers to Advance Care Planning

• What are the biggest challenges you face?
  – Logistically/practically (in your setting)
  – With patients (our population)
  – Introducing the subject
Barriers are real

- Patient
- Culture
- System
- Provider
Barriers with *our* patients

- Studies done in SFGH GMC
  - Feel ACP is irrelevant
  - Too sad/too busy
  - Don’t have surrogate/don’t want to burden
  - Health encounter time constraints
  - Don’t understand forms/need help
  - Need more info about health/choices

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Where do we go from here?

- Rethinking goals and approach
- Introduce tools
- Discuss updates
Redefining ACP Goals and Establishing Priorities

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Redefining ACP Goals

• ACP is a *process*, more about *dialogue* and *clarifying values* than completing forms
• Patients have to be ready to engage in ACP
• Our goal is to understand patient’s level of readiness, and help motivate them to move through the process
ACP and Motivational Interviewing

Pre-contemplation

Contemplation

Action
- Discuss with family
- Discuss with clinicians
- Document

Maintenance
Determining Patient Readiness

• Prior engagement with ACP
  – Personal experience
  – Surrogacy
• Insight into health, function
• Clarification of personal values, wishes
• Discussions about values, wishes
  – With family/friends
  – With clinicians
A New Approach to Individual Patients

- Determine readiness stage
- Provide education and assistance appropriate for readiness stage
- Reassess/readdress over time
Pre-contemplation
- Little/no insight into declining health condition
- No advance planning for emergency care
- No identified or documented surrogate decision-maker

Contemplation
- Some insight into severity of condition, recognize decline, may voice concerns related to condition
- May have thought about wishes but has not communicated them to anyone
- May be able to name a potential surrogate but has not completed DPOA form

Preparation & Values Clarification
- Willing to engage, discuss health condition; may or may not want information on prognosis
- Willing to engage in conversation about values related to health care
- Willing to consider filling out advance directive or POLST

Action
- Has insight into severity of condition, recognizes decline, may voice concerns related to condition
- Recognizes that advance care planning is important, and states plan/intention to formalize preferences in advance directive and/or DPOA designation
- May have discussed preferences with provider and/or friends/family, or is planning to do so

Maintenance
- Has insight into severity of condition
- Has completed some form of advance directive
- May have discussed preferences with provider and/or friends/family
Think about your patients

• Identify 1-2 of your patients with progressive illness, who you think needs to engage in advance care planning
  – What stage of readiness do you think s/he is at?
  – What are your priorities in advancing this conversation in follow up visits?
Another way to approach ACP

- High-Need Pts
- At-risk Patients
- All Patients
• Screen for prior advance directive completion
• **Identify surrogate decision maker**
• Assess reaction to advancing illness in friends, family
• Routinely assess level of insight into disease severity, patient fears/concerns, readiness for advance care planning
• Discuss specific treatment decisions, near- and long-term
• Clarify goals, values over time
• Engage surrogate whenever possible
• Routinely assess level of insight into disease severity, patient fears/concerns, readiness for advance care planning

• Discuss specific treatment preferences
  – Emergency care
  – End-of-life care

• Document wishes, values, specific preferences
  – Goals/wishes
  – POLST, Advance Directive/DPOA
Barriers are real

- Patient
- Culture
- System
- Provider
Practical Realities

• Conversations take time
  – Take “on ramp” opportunities

• Standard practice primarily involves PCP
  – Who else could partner in ACP in your clinic?

• EMR challenges
  – LCR recommendations
    • Clinical alert
    • “Advance Directive” note
    • “Advance Directive” tab (~ POLST)
Welcome to PREPARE!

PREPARE is a program that can help you:

- make medical decisions for yourself and others
- talk with your doctors
- get the medical care that is right for you

You can view this website with your friends and family.

Click the NEXT button to move on.
Creative Ways to Activate Patients

ACP Decisions (www.acpdecisions.org)
• Evidence-based approach using videos to educate and motivate pts in ACP
• Large library of resources for pts, providers, including how-to guide, checklist
• Paid subscription
What is Artificial Hydration?

Artificial hydration is a medical treatment that provides water and salt to someone who is too sick to drink enough on their own or who has problems swallowing.

Artificial hydration is given through:
- an IV in a vein or under the skin,
- a tube placed through the nose into the stomach, or
- a tube is placed by surgery through the skin into the stomach or intestines.

Does artificial hydration work?

This depends on how sick someone is and whether they are near the end of their life. Some people enjoy years of satisfying life while using artificial hydration.

For people who are NOT near the end of their lives, artificial hydration may help.

For people near the end of life, and in late stages of dementia (memory loss), it is normal for people to stop drinking.
- At the end of life, the body becomes unable to use water and salt.
  - Because of this, artificial hydration can cause:
    - water build up on the legs
    - water build up in the lungs

For people near the end of life, artificial hydration does not prevent dry mouth.
- People close to death often breathe through their mouth.
- Most people who are dying will have a dry mouth.

什麼是呼吸器?

呼吸器是幫助您呼吸的一個機器。它可以幫助因重病而無法自行呼吸的病人或需要長期呼吸輔助的病人來呼吸。

呼吸器並不能治療或治療肺部的問題。
當醫生嘗試治療呼吸方面的問題時，會使用呼吸器。

呼吸器又可以稱為機械通氣。

使用呼吸器時會是什麼樣的情形?

What is it like to be on a ventilator?

- 有一根管子會從口腔插進氣管（氣管插管）。
- 機器會經由管子，將空氣強制打到肺部。
- 為了減輕病人的不適，一般會給藥物使病人昏睡。
- 病人通常不清醒的，也不能講話或吃東西。

幾天後：
- 醫生會把使病人昏睡的藥量減低，以測試病人是否可以自行呼吸。
- 如果可以自行呼吸，就會拔除氣管插管。

幾個星期後：
- 醫生可能需要在氣管上做個切口，放入管子，這個過程叫做氣管造口術。
- 病人也許需要進住院護理之家，不然就需要特別的住家護理。

對於呼吸管經由口腔插入，病人是怎麼感覺呢?

What do people say a ventilator feels like when a breathing tube is placed through their mouth?

當呼吸管穿過喉嚨時，有些人一直是昏睡的，並不記得曾經用過呼吸器。
但是，有些清醒的人可能感覺：
- 一切都好。
- 因插管或強制將空氣打入肺裡所造成的疼痛。
- 害怕，感覺被壓住。
- 有痰或咳嗽的問題。
Other Tools/Resources

• Chinese American Coalition for Compassionate Care
• Videos/documentaries
  – Frontline: Being Mortal
  – Consider the Conversation
• Conversation Guides
  – Serious Illness Conversation Guide (Harvard)
  – The Conversation Project
POLST

- Experiences using POLST
  - Available to you?
  - How and when do you introduce it to pts?
  - What do you do with it?
  - Acted on (or not)?
POLST

• Suggestions
  – Best for pts
    • Limited prognosis (1-2 yrs)
    • Prefer some limitations on aggressive care
      – Code status
      – Hospitalization
      – Artificial nutrition
  – Action step at end of ACP conversation, not main focus
• Use of translated versions
• Recent changes
  – Wording in section B
  – NPs and PAs can now complete POLST
• Education available for providers
Next steps

• Which patients do you want to prioritize?
• What further training/practice do YOU need?
• Who can you partner with to improve ACP in your setting?