Advance Care Planning

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Disclosures

- No conflicts of interest to disclose

Objectives

- Understand the importance and benefits of advance care planning
- Describe and utilize various forms of advance directives
- Apply conversational techniques to assist patients with advance care planning
- Identify legal and ethical implications and consider resources to address these

What happens when we can’t prevent everything?

…2 things are certain

But we can still prevent:

- STRESS:
  - Goals of care discussion and advanced care directives have been found to increase patient satisfaction and decrease family stress. (Spoelhof, 2012)

- UNWANTED PROCEDURES:
  - Study of Oregon POLST revealed in NH patients no one received unwanted procedures (Tolle 1998)

- ADDITIONAL DISCOMFORT IN DEATH AND DYING:
  - In 2019 study on Oregon where POLST is statewide, complete registry, and much effort on public education, there is a 2/3 rate of patients dying at home vs 39.6% rest of country. (Tolle 2017)

EVIDENCE

- They are most effective when done over multiple visits (Spoelhof, 2012)
- Specific conversation relevant to a patient's stage in life improves completion rates (Spoelhof, 2012)
- In a systematic review, 70% of patients' preferences as expressed in an advanced care planning conversation were stable over time. EOL preferences included CPR, artificial nutrition and hydration, mechanical ventilation, surgery, antibiotics, dialysis, transfusion, hospitalization, ICU admission, nursing home admission, will to live, attitudes toward euthanasia, attitudes toward physician-assisted suicide, and decision-making preferences (Auriemma 2014).
- Preference stability in this study was greater among inpatients, seriously ill outpatients, higher education, those who had already engaged in advanced care planning, and those choosing to forego therapy (as opposed to those choosing to receive therapy) (Auriemma 2014).
- A survey from patients with cancer revealed a desire to discuss ACP with family (85%) doctors (70%) and to formally document (73%). (Waller 2019)

What is it?

Advance Care Planning?

Advance Directives?

What is the goal?

- Patient Autonomy!
- Make sure patients get the care they desire

- Legal and medical documentation

Types of Advance Directives:

- Living Will
- Durable Power of Attorney for Health Care/Medical POA/"Proxy"
- Physician Orders for Life-Sustaining Treatment (POLST)
- Combined Directives
- DNR/DNI/DNH
- Organ Tissue Donation

- An advance directive is a legal document that says how you want to be cared for if you are unable to make decisions.
- Only goes into effect once a patient loses decision making capacity

Living Will:

- A living will (LW) is a list of treatment preferences.
- Summarizes patient preferences for future care.
- Used to indicate preference for CPR, tube feedings, intubation, dialysis, or certain medicines like antibiotics/blood products/chemo/pain control.
- Besides life-support and resuscitation, a LW is also used for preferences regarding hospitalization (DNH).

Medical POA:

- The "durable power of attorney for health care" (DPAHC) document identifies the person the patient wants to make his/her medical decisions. This person is also called a "proxy". The proxy should be familiar with patient's values and wishes.
- This only happens in the event the patient loses decisional capacity.

- Started in the 1990's when states started recognizing the long-term limitations of LW.

POLST:

A POLST form tells **all** health care providers during a medical emergency what your patient wants:

- “Take me to the hospital” or “I want to stay here” (DNH)
- “Yes, attempt CPR” or “No, don’t attempt CPR” (DNR)
- “These are the medical treatments I want”
- “This is the care plan I want provided to me”

A medical order that travels with the patient (called a POLST Form) - not institution or state specific!

POLST includes medical orders, signed by a doctor, effective immediately (not when the patient loses DMC) , so considered "portable".

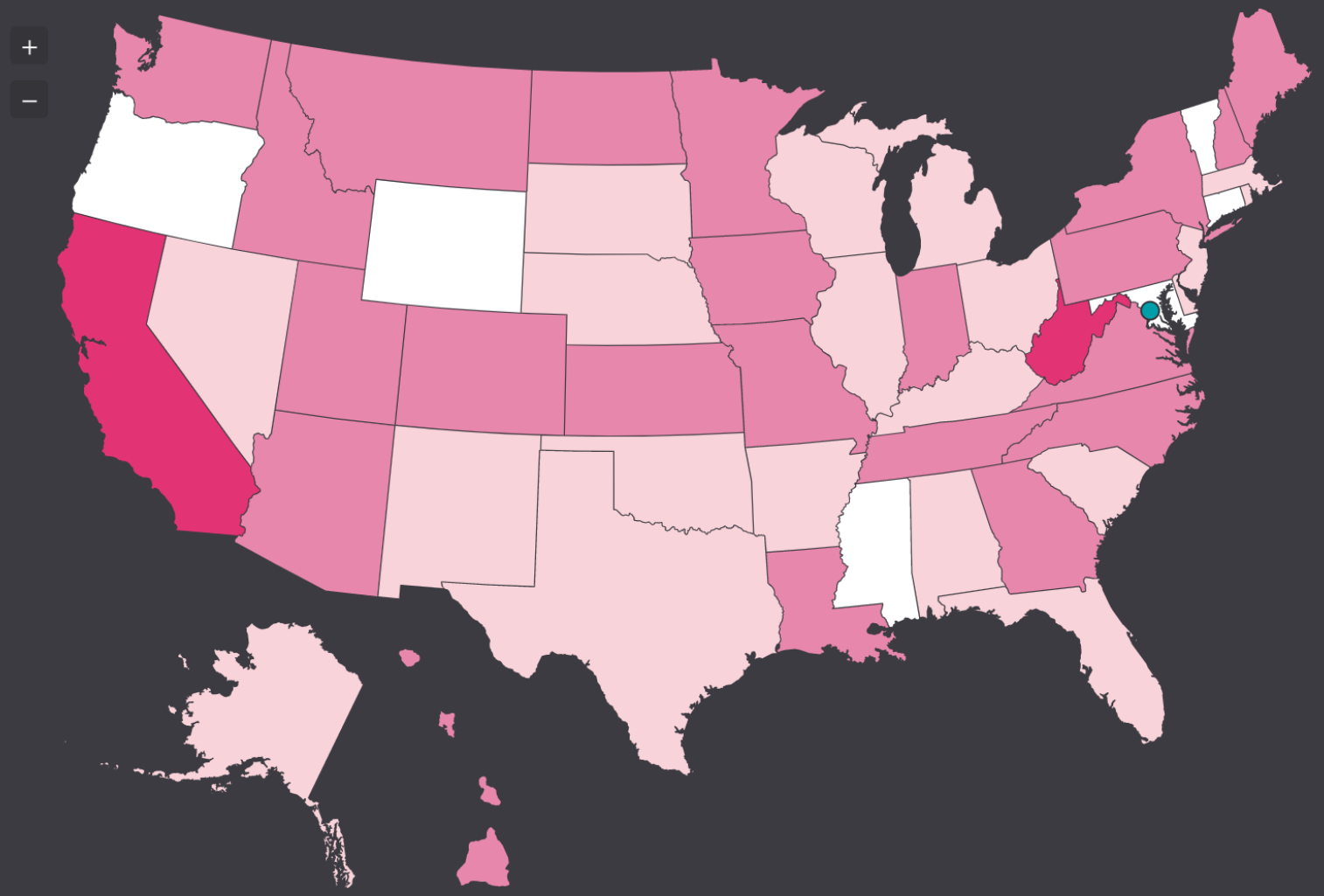
National POLST Paradigm Program Designations

Click a state for more information

- 2 mature
- 24 endorsed
- 21 active
- 6 unaffiliated

Only active programs are eligible for endorsed status; unaffiliated status does not reflect program development. Mature programs also endorsed and counted in both the mature and endorsed program totals. Totals include Washington DC.

LEARN MORE in the text below the map



« BACK TO MAP

Oklahoma

Status: Active.

STATE	Oklahoma
PROGRAM CONTACT	Jan Slater, JD, MBA Executive Director jslater1105@gmail.com
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PROGRAM NAME	OkPOLST - Oklahoma Physician Orders for Life-Sustaining Treatment
PROGRAM WEBSITE	http://www.okpolst.org/
STARTED ON	2007
LEGISLATIVE INFORMATION	2016 HB 3017 OK Physician Orders for Life-Sustaining Treatment Act

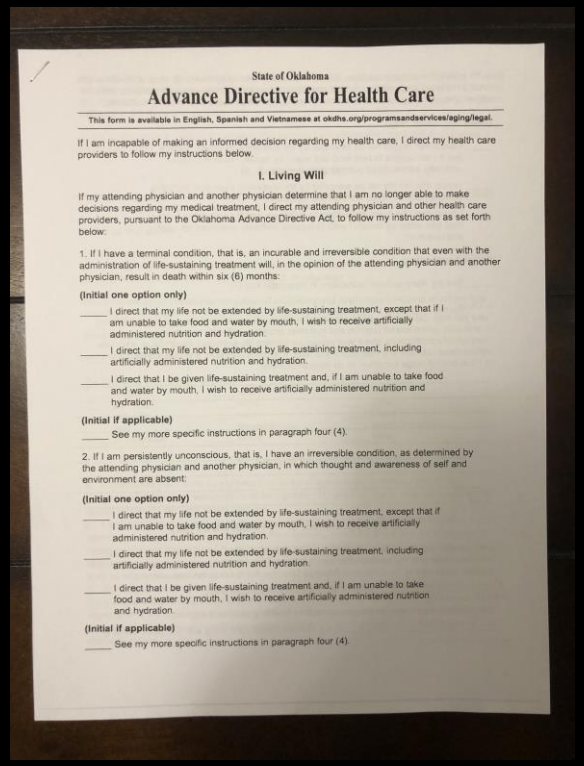
Oklahoma POLST stands for Oklahoma **P**hysician **O**rders for **L**ife-**S**ustaining **T**reatment. It is a physician's order that documents and directs a patient's medical treatment preferences when faced with life-limiting illnesses and irreversible conditions. The form is influenced by the National POLST Paradigm and represents a model for end-of-life care.

The mission of Oklahoma POLST (OkPOLST) is to improve end-of-life care for Oklahomans by creating documents and programs that promote honoring the health care wishes and goals of care for those with life-limiting and irreversible conditions.

OkPOLST Form	Advance Directive
For seriously ill/frail, at any age	For anyone 18 and older
Specific orders for current treatment	General instructions for future treatment
Can be signed by legal health care representative	Appoints a legal health care representative
Provides guidance for emergency medical personnel	Does not guide emergency medical personnel
Travels with a patient across health care settings	Difficulty locating AD during times of crisis
Algorithmic document outlines medical treatment preferences	Sometimes difficult to interpret
Becomes effective when the form is signed by patient and provider	Becomes effective when a patient cannot speak for himself/herself

State Programs choose their own names and the full list includes:

- POLST (Physician Orders for Life-Sustaining Treatment)
- POST (Physician Orders for Scope of Treatment)
- MOLST (Medical Orders for Life-Sustaining Treatment)
- MOST (Medical Orders for Scope of Treatment)
- TPOPP (Transportable Physician Orders for Patient Preference)
- COLST (Clinician Order for Life Sustaining Treatment)
- DMOST (Delaware Medical Orders for Scope of Treatment)
- IPOST (Iowa Physician Orders for Scope of Treatment)
- TOPP (Transportable Orders for Patient Preferences)
- AzPOLST (Arizona Provider Orders for Life-Sustaining Treatment
- LaPOST (Louisiana Physician Orders for Scope of Treatment)
- OkPOLST (Oklahoma Physician Orders for Life-Sustaining Treatment)
- PAPOLST (Pennsylvania Orders for Life-Sustaining Treatment)
- WyoPOLST (Wyoming Providers Orders for Life-Sustaining Treatment)
- SAPO (State Authorized Portable Orders)
- SMOST (Summary of Physician Orders for Scope of Treatment)



State of Oklahoma

Advance Directive for Health Care

This form is available in English, Spanish and Vietnamese at okdhs.org/programsandservices/aging/legal.

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

I. Living Will

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

1. If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

(Initial one option only)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

_____ See my more specific instructions in paragraph four (4).

2. If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

(Initial one option only)

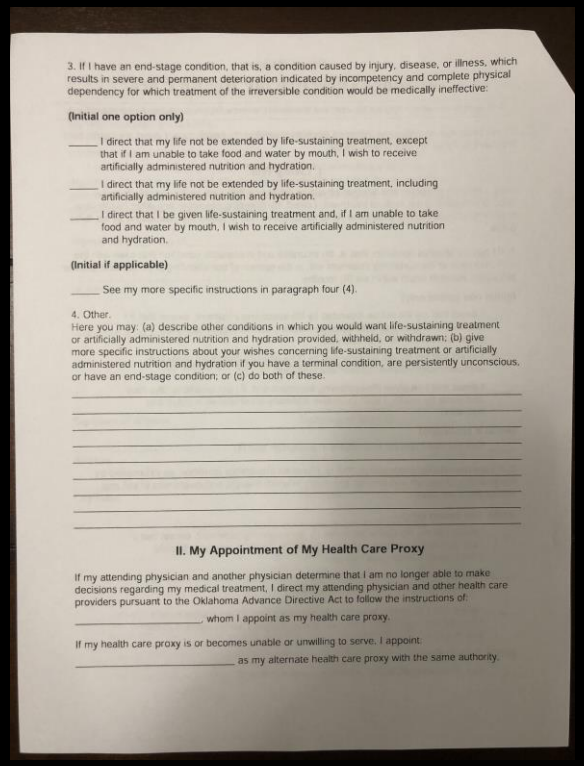
_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

_____ See my more specific instructions in paragraph four (4).



3. If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

(Initial one option only)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

_____ See my more specific instructions in paragraph four (4).

4. Other.
Here you may: (a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn; (b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition; or (c) do both of these.

_____
_____
_____
_____
_____
_____
_____
_____
_____

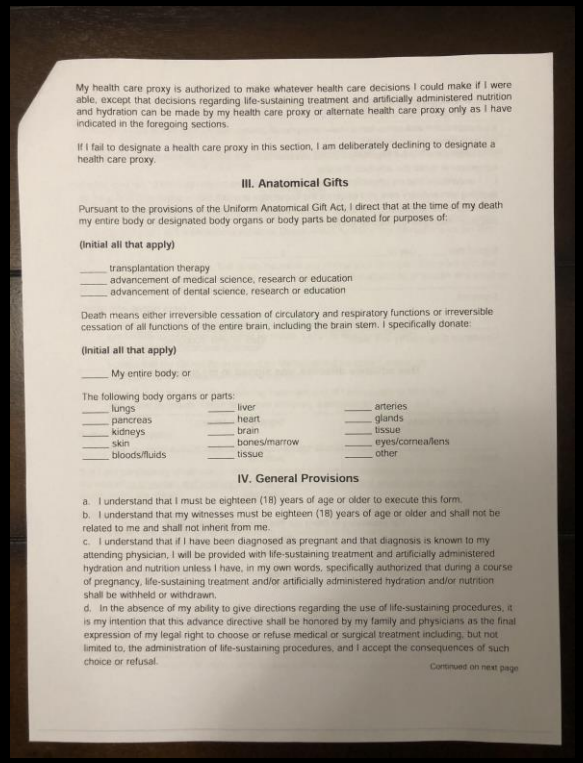
II. My Appointment of My Health Care Proxy

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of:

_____, whom I appoint as my health care proxy.

If my health care proxy is or becomes unable or unwilling to serve, I appoint:

_____ as my alternate health care proxy with the same authority.



My health care proxy is authorized to make whatever health care decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

III. Anatomical Gifts

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

(Initial all that apply)

_____ transplantation therapy
_____ advancement of medical science, research or education
_____ advancement of dental science, research or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. I specifically donate:

(Initial all that apply)

_____ My entire body; or

The following body organs or parts:

_____ lungs	_____ liver	_____ arteries
_____ pancreas	_____ heart	_____ glands
_____ kidneys	_____ brain	_____ tissue
_____ skin	_____ bones/marrow	_____ eyes/cornea/lens
_____ bloods/fluids	_____ tissue	_____ other

IV. General Provisions

a. I understand that I must be eighteen (18) years of age or older to execute this form.
b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.
d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.

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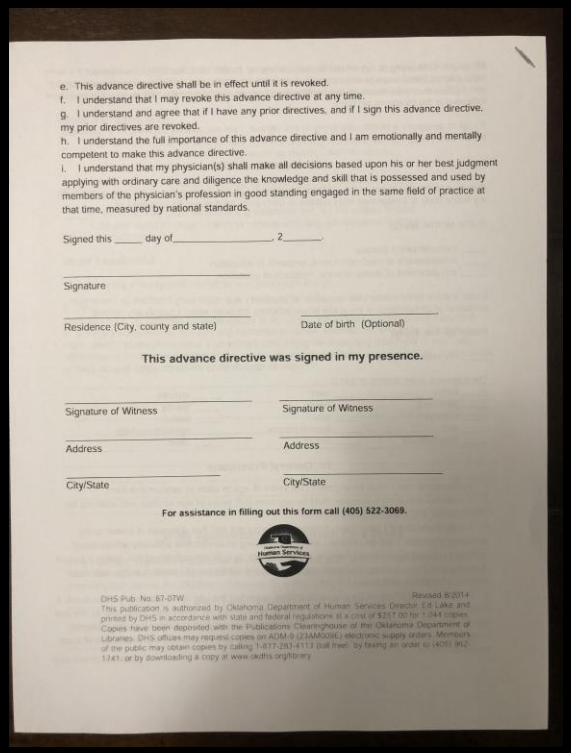

e. This advance directive shall be in effect until it is revoked.
f. I understand that I may revoke this advance directive at any time.
g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.
i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

Signed this _____ day of_____, 2_____.

_____
Signature

_____ _____
Residence (City, county and state) Date of birth (Optional)

This advance directive was signed in my presence.

_____ _____
Signature of Witness Signature of Witness

_____ _____
Address Address

_____ _____
City/State City/State

For assistance in filling out this form call (405) 522-3069.

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Oklahoma's Living Will:

Downloads – okpolst

Barriers to Completion:

Doctors:

- Time
- Discomfort

Patients:

- Fear
- Burden to others
- Lack of knowledge (x2)
- Want/Expect the doctor to initiate

Barriers to Implementation:

1. Directive is too vague
2. Inaccessibility!

Barriers and Solutions to Implementing Advance Directives

BARRIER	*SOLUTION*
End-of-life terminology: When do care preferences apply?	Clarify vague terms, such as “terminal” and “no hope of recovery”
Clinical relevance of care requests: What types of procedures are requested and declined?	Clarify vague terms, such as “life support” and “no heroics,” and indicate wishes regarding specific scenarios and interventions; have ongoing conversations with the patient
Proxy issues: Is the proxy aware of the advance directive contents and patient wishes?	Include proxy in discussions regarding advance directive
Advance directive accessibility: Is the advance directive part of the medical record and readily accessible to physicians, proxy, and family members?	Include advance directive in the medical record at the office and hospital and be sure it transfers with the patient to other levels of care

Facilitating ACP:

- Schedule a separate visit!
- (make sure the proxy is present)

- Obtain permission:
  - Can be emotional, even if healthy
- Should be involved?
  - Preferences/Proxy
- Establish a baseline:
  - Assess the pt's knowledge.....?

- Provide specific information:
  - Relevant to the patient
- Pose the questions:
  - Introduce the dilemmas
- Explore values and beliefs:
  - Goal: "Live well"/"quality of life
- Elicit ACP Preferences:
  - Identify what they want – be specific!
- Revisit regularly:
  - AD's are mailable and ongoing, they should change as pt's health changes

The Conversation- Perspectives

Exercise-Patient Perspective

70 yo male with mild dementia, memory loss

arthritis, CHF, difficulty hearing and seeing

*Functional status—difficulty walking, some incontinence, falls, diminished appetite, mild difficulty sleeping and dyspnea

- What is your most bothersome symptom?
- What are your hopes?
- What are your fears?
- What do you value?

Exercise-Physician Perspective

70 yo male with mild dementia, memory loss

arthritis, CHF, difficulty hearing and seeing

*Functional status—difficulty walking, some incontinence, falls, diminished appetite, mild difficulty sleeping and dyspnea

- What do you think bothers your patient the most?
- What do you hope for his future?
- What is your biggest concern for his health?
- What would you want to know about your patient's health values?

Exercise

70 yo male with mild dementia, memory loss

arthritis, CHF, difficulty hearing and seeing

*Functional status—difficulty walking, some incontinence, falls, diminished appetite, mild difficulty sleeping and dyspnea

- What did you learn that is similar or differs between the two perspectives?
- How can you phrase these questions to make them comfortable for your use as a clinician?
- Which questions are most pertinent to include in an advanced care directives conversation?
- How do these questions differ from our typical encounter?

What do patients need to understand beforehand?

- Condition
- Symptoms to expect
- Treatment options
- Progression of disease
- Prognosis

What do you say? Ask?

- Align patients hopes and value with medical care and express this is your interest.
  - “Keeping in mind your hopes, I’d like to discuss with you some options or documents that can help ensure we keep your medical care in alignment with your values…”
- Draw analogy to insurance or back-up plan to ensure we treat them as they would like— identifies need for personalization and autonomy.
  - “I would like to show you some documents that are like an “insurance” you would include in these documents your wishes and guide the decisions regarding your health care…”

How would you ask about resuscitation?

A 78 yo M with PMH of chronic smoking history and COPD on supplemental oxygen established care with you last month. During your initial visit, you brought up APC and agreed to bring the pt back for further discussion and documentation. You had briefly discussed the concept of a proxy and told the patient to bring a trusted family member or friend if he had anyone in mind. At today's visit, he presents to clinic alone and states he did not do any individual research, he "just want you to help him make the right decisions".

Stage	*Discussion points*	*Actions*
Routine patient visit, patient 50 to 65 years of age	"If you were to get very sick, who would you trust to make medical decisions for you?" "Have you thought of completing an advance directive?" "How would you like to be cared for if you had a devastating injury or illness?"	Provide advance directive forms Review forms, and offer to answer questions (review again at later meeting) If possible, offer a group session to introduce advance directive topics to multiple patients

Diagnosis of progressive chronic disease (e.g., heart failure, cancer, dementia, chronic obstructive pulmonary disease)	"Your health has changed. What is your understanding of your condition?" "Do you have any feelings about what you have experienced so far?" "Have your goals for care changed?" "Have you discussed your feelings with your loved ones?"	Offer to meet with patient, proxy, and family members Discuss how changes in health may have changed advance directive goals, and update forms

Increasing frailty and dependency (e.g., patient admitted to nursing home)	"If time becomes short, what is most important to you?" "Have you spoken to your proxy about any changes in your care goals?"	Meet with patient, proxy, and family members Discuss prognosis and personal goals Review life support and resuscitation options in detail, and update advance directive forms

Considerations:

DECISION-MAKING **CAPACITY**

ETHICAL **ISSUES**

LEGAL **ISSUES**

Pt is a 70 yo FM with ARDS 2/2 COVID-19. She is intubated and unconscious in the intensive care unit complicated further by acute renal failure. Her advance directive, completed seven years ago when she was highly functional, indicates that she wants life-sustaining treatments. She has not updated her advance directive since that time. Members of the medical team are concerned that she has little chance of surviving this hospital stay, and if she were to survive, she is at high risk of significant cognitive deficits that would require long-term skilled nursing care. The patient's husband is listed as her health care agent in her advance directive. He asks how he should proceed with decision making as he struggles to balance what he thinks would be in his wife's best interest and what she has indicated in her advance directive.

WHEN PREVIOUSLY EXPRESSED WISHES CONFLICT WITH BEST INTERESTS

A five-question framework has been proposed to help clinicians determine whether to focus on the patient's previously expressed wishes or on the current best interest of the patient:

1. Does the urgency of the clinical situation require a time-sensitive decision, are the patient's previously expressed wishes clear, and are POLST documents completed and available?

2. Considering the patient's preferences and goals of care, are the burdens of the intervention likely to overshadow the benefits?

3. Is the advance directive appropriate in the current situation?

4. How much leeway does the surrogate have to interpret the patient's advance directive?

5. Is the surrogate acting in the patient's best interests?

AID TO CAPACITY EVALUATION (ACE)

Microsoft Word - Aid To Capacity Evaluation.doc (uiowa.edu)

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