Advance Health Care Planning: Why and How

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What is advance care planning?

How do you begin discussions about advance directives?

Identify barriers to formulating plans.

Identify some tools and resources for completing advance directives.
Protect Yourself

Universal Living Will

with
Durable Power of Attorney for Health Care

And N.Y. new PROXY LAW form

Complies with Supreme Court Cruzan Decision
Provides "clear and convincing evidence"
in COMATOSE or TERMINAL condition

Plus Wallet Size Abridged Will

$10 + $1  P&H

Universal Living Wills, Inc. Dept. A
NY Residents add Tax - 7985 E. Quaker Rd.
P.O. Box 986 Orchard Park, NY 14127
Living Will
Durable Power of Attorney for Health Care
Health Care Proxy
Combined Directives
POLST
MOLST
Five Wishes
Medical Directive

- Treatments
- Specific Situations
- Documents

- Attitudes
  - Health
  - Life
  - Independence
  - Control
What is Advance Care Planning (ACP)

- Planning for future medical care in the event patient is unable to make own decisions
  - Needs to be updated regularly
- Empowers patient to explore own values, goals
- Determine proxy decision-maker
- It is a process, not an event
- Proper documentation avoids confusion & conflict
Terms Used in Advance Care Planning (ACP)

- **Instructions for Medical Care**
  - Living will
  - Verbal statements
  - Personal letter or value statement stating preferences
  - The 5 Wishes

- **Designation of proxy**
  - Health Care Proxy or Agent
  - Durable Power of Attorney for Health Care

“Advance Directives”
Patient Barriers to Completion of Advance Directives (AD)

- Belief that physicians should initiate discussions*
- Procrastination
- Apathy
- Belief that family should decide
- Family would be upset by the planning process
- Fear of burdening family members
- Discomfort with the topic
- Death - denying society

Patient-Provider Communication About Advance Directives

- Survey of Medical Oncologists
  - 25% knew of existence of patients’ AD

- Survey of Ambulatory Patients
  - 30% of patients who had completed an AD notified their primary care MD

- Survey of Nursing Home Charts
  - 25% of completed AD disappeared from the nursing home chart after 2 years
Controlled trial to improve care of seriously ill hospitalized patients

Multicenter study funded by RWJ

9000 patients with life threatening illness
  - 1st phase: How people die in hospitals
  - 2nd phase: RCT of nurse-based intervention, 2500 subjects in each group
(1993 National Mortality Followback Survey)

- Hospitals, 56%
- Nursing homes, 19%
- Home, 21%
- Other, 4%
Physician Did Not Understand That a Patient Wanted to Avoid CPR
Experienced Moderate or Severe Pain at Least Half of the Time Within Their Last Few Days

50%
Impact of Serious Illness on Patients’ Families

Needed large amount of family caregiving 34%
Lost most family savings 31%
Lost major source of income 29%
Major life change for family member 20%
Other family illness from stress 12%
At least one of the above 55%

(SUPPORT JAMA 1994;272:1839-1844)
- His living will also defines as extreme treatment depleting the family's life savings to keep him alive after his insurance runs out!!
Support for Advance Care Planning

- Ambulatory elderly patients
  - 87% favored routine discussion

- Nursing home residents
  - 69% favored advance care planning

- 493 hospitalized patients
  - 80% favored discussion of AD
...Fantasy Death: There are Common Themes

- Feeling at home, or being at home
- Comfort
- Sense of completion (tasks accomplished)
- Saying goodbyes
- Life review
- Love
- No pain
- Make it quick
Clarify Goals, Treatment Priorities

- Goals guide care
- Assess priorities to develop initial plan of care
- Review with any change in:
  - Health status
  - Advancing illness
  - Setting of care
  - Treatment preferences
- Advance Care Planning
# How do Advance Directives differ from DNR?

<table>
<thead>
<tr>
<th>ADVANCE DIRECTIVES:</th>
<th>DNR or DO NOT RESUSCITATE:</th>
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<tbody>
<tr>
<td>Should be considered by anyone and everyone</td>
<td>Should be considered by people who have risk factors for not surviving resuscitation</td>
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<tr>
<td>Applies to all general medical treatments</td>
<td>Applies only in case of cardiopulmonary arrest</td>
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<tr>
<td>Document usually requires patient signature</td>
<td>Document does not require patient signature</td>
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</tbody>
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Values and Beliefs

- If talking is so important – why is it so HARD?
- Triggers - family events, movies, news items
- Never assume we know family, loved ones or friends wishes
- Often as we examine our own values this helps in opening a conversation.
Dying is part of living.
• Need to approach it openly despite its difficulty

Advance directives (AD) empower patients to reflect on their values, meaning of life, and illness experiences

Often avoid a crisis during active dying

A gift you give your loved ones

AD help clarify patient’s wishes as to plan of care, and foster the patient-provider relationship

Allows patient and family to truly make a “good death” memory
"To cure sometimes,
To relief often,
To comfort always."

- 15th C French saying
AD Case A:

- A 79 year old woman is on her way to see her provider, and remembers suddenly that she needs to complete her Health Care Proxy form for this visit. She encounters 2 of her neighbors and asks them to do her the favor of signing her proxy form, which they do.

Discussion:
- **a.** What is a Health Care Proxy or Agent?
- **b.** How should a Health Care Agent be appointed?
Mr. Sullivan is 72 years old. He has had lung cancer for 9 months and is now at the end stage. He is admitted to the hospital for what you think will be his final admission. He is very likely to suffer pulmonary or cardiac arrest. Should you raise the issue of a DNR order?

- His chances of surviving resuscitation is about 10%. There is a 90% chance he will die anyway.

- His chances of leaving the hospital alive is <2%.
QUESTIONS??????