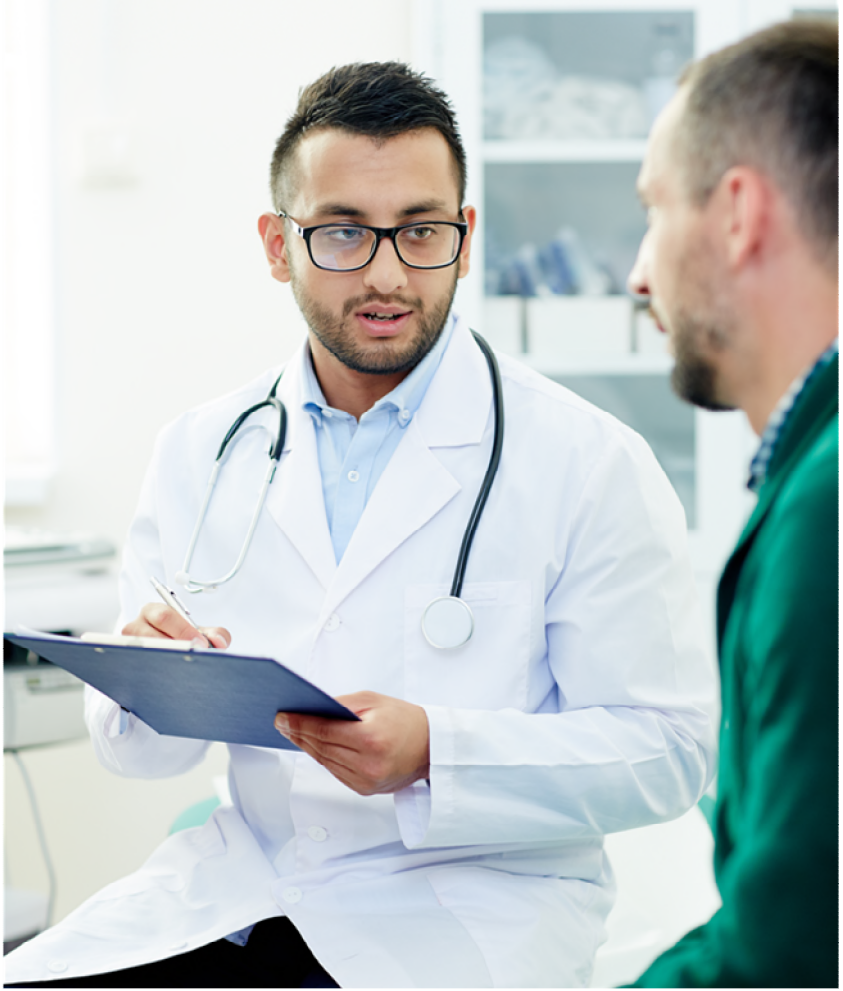
ADVANCED CARE PLANNING

Michael Hochman, MD, MPH
Healthcare in Action
December 16, 2021

Disclosures

I do not have anything to disclose.

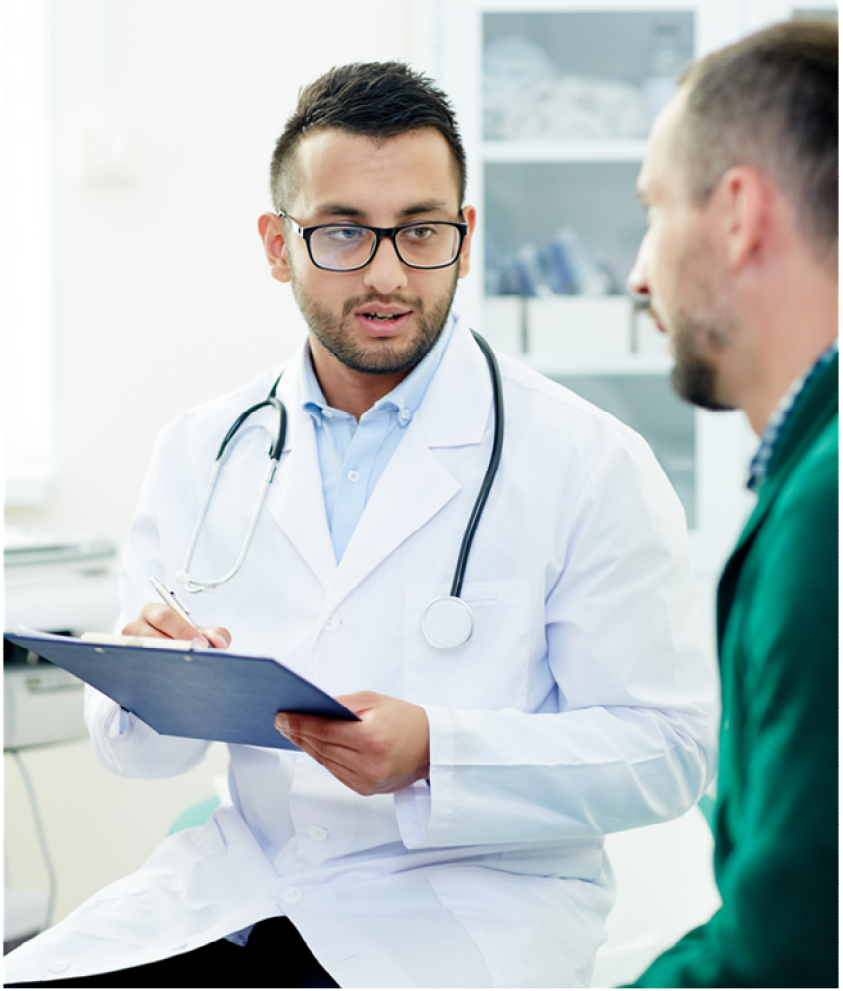


Agenda

01 What is Advanced Care Planning

02 The Evidence

03 A Checklist



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01 **What is Advanced Care Planning**

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Advanced Care Planning

Robert Janett, MD
The Cambridge Health Alliance

“Stop focusing on getting the DNR/DNI!”

Advanced Care Planning

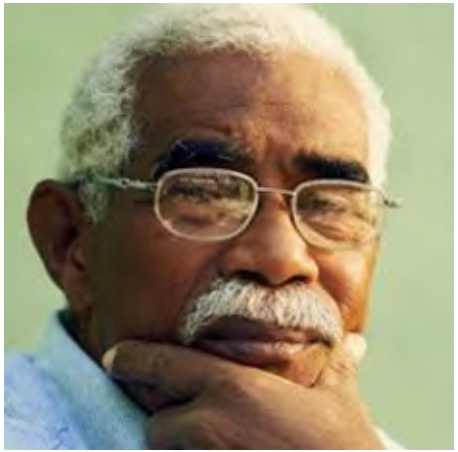
"Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness."

- Sudore et al. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. J Pain Symptom Manage. 2017 May;53(5):821-832.

Advanced Care Planning

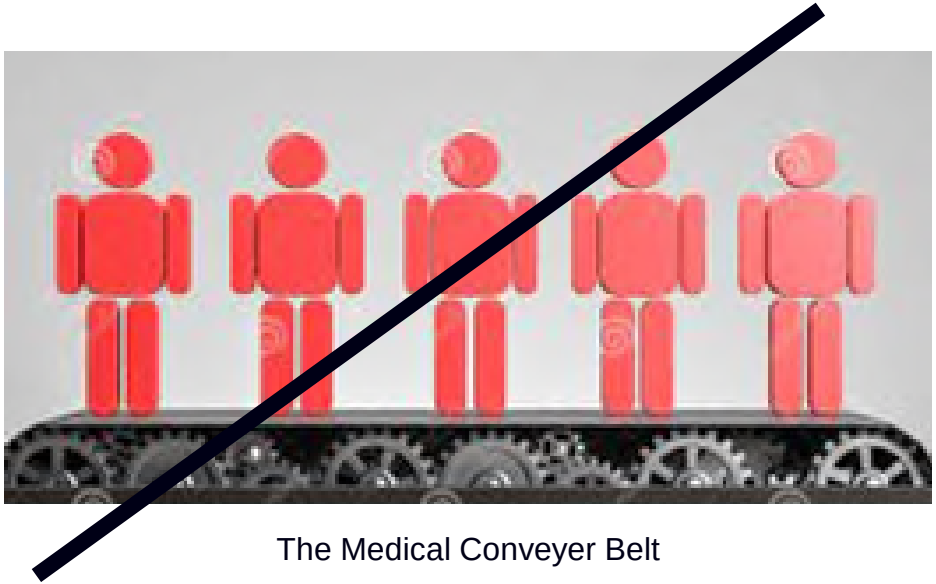
- 86 yo man with atrial fibrillation sees primary doctor for dyspnea on daily walk to grocery store
- HR 106 on exam
- PCP orders pharmacologic stress test and echo
- Referred to cardiology with reversible ischemia and low ejection fraction
- Receives cardiac catheterization with PCI
- Experiences post-op bradycardia and receives a biventricular pacemaker

Advanced Care Planning

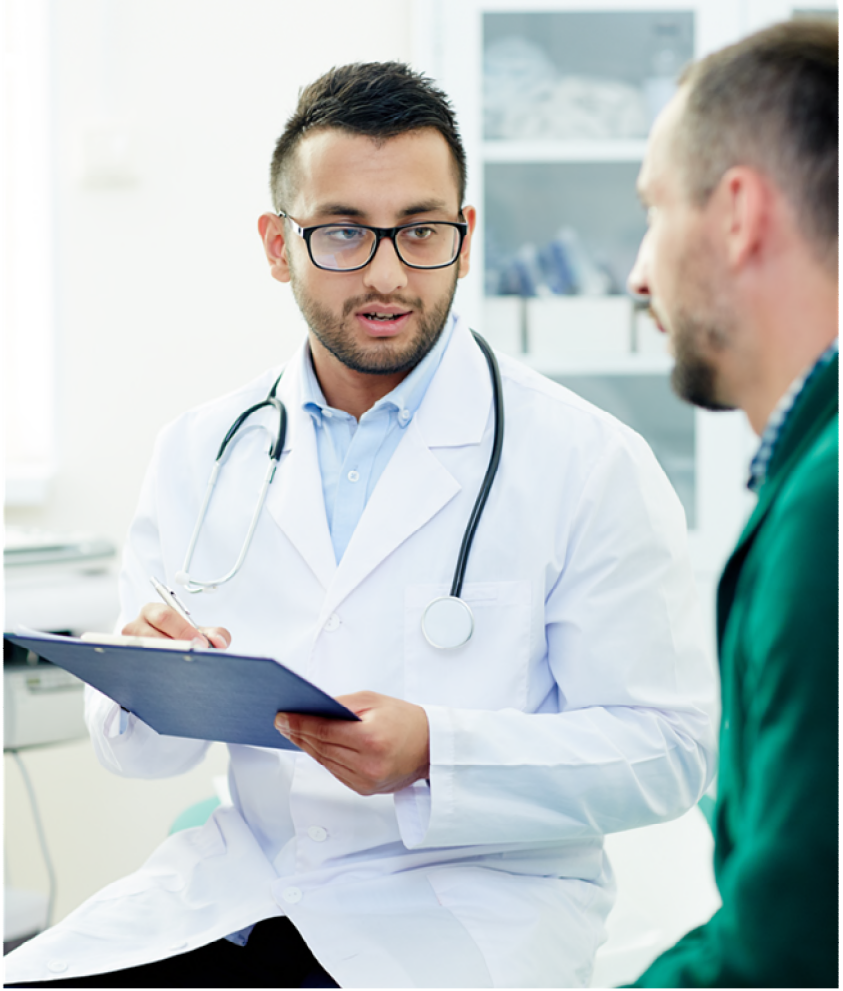


“Now I can’t even make it to the grocery store on my walk. Going to my primary doctor that day was a bad idea.”

Advanced Care Planning



The Medical Conveyer Belt



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Impact on Adherence to Patients' Wishes

- **Site:** Australia, 2010
- **Population:** 309 inpatients aged 80+
- **Design:** RCT comparing facilitated ADL discussions vs. usual care
- **Results:**
  - 70% completed the process in facilitated group
  - Among those who died, 86% of family members understood patient wishes vs. 30% of controls
  - Higher patient and family satisfaction

Detering et al. BMJ. 2010 Mar 23;340:c1345.

Impact on Resource Utilization

- **Site:** Canada, 2000
- **Population:** 1292 nursing home residents
- **Design:** RCT comparing systematic advanced directives discussions vs. usual care
- **Results (18 months):**
  - 49% of competent residents and families of 78% of incompetent residents completed process
  - 0.27 (intervention) vs. 0.48 (control) admits
  - Average costs $3500 vs. $5200

Molloy et al. Systematic implementation of an advance directive program in nursing homes: a randomized controlled trial. JAMA. 2000 Mar 15;283(11):1437-44.

Rates of Advanced Directive Completion

What percentage of U.S. adults have formally completed advanced directives (i.e. written document)?

A) 75%
B) 50%
C) 35%
D) 10%

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Yadav et al. Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care. Health Aff (Millwood). 2017 Jul 1;36(7):1244-1251.

Stability of Advanced Directives

What percentage of patients will change advanced directives during a hospitalization?

A) 25% will add a limitation in life-sustaining treatment while 10% will remove such limitations.

B) 10% will add a limitation in life-sustaining treatment while 25% will remove such limitations.

C) 15% will change their directives, equally split between adding and removing limitations.

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Kim et al. The Natural History of Changes in Preferences for Life-Sustaining Treatments and Implications for Inpatient Mortality in Younger and Older Hospitalized Adults. J Am Geriatr Soc. 2016 May;64(5):981-9.

Real-World Experience with Advanced Directives

"The proportion of decedents with an advanced directive increased from 47% in 2000 to 72% in 2010. At the same time, the proportion of decedents with at least one hospitalization in the last 2 years of life increased from 52% to 71%."

Silveira et al. Advance directive completion by elderly Americans: a decade of change. J Am Geriatr Soc. 2014 Apr;62(4):706-10.

Resuscitation Orders

- 80 year-old woman with mild cognitive impairment and NYHA class II CHF presents for an advanced care planning discussion

“Why wouldn’t I want to be resuscitated, doctor?”

Outcomes of CPR

Among survivors of out of hospital cardiopulmonary arrest, what proportion will experience bran injury and/or nursing home admission within a year?

A) 5%
B) 10%
C) 20%
D) 50%

Outcomes of CPR

Among survivors of out of hospital cardiopulmonary arrest, what proportion will experience bran injury, nursing home admission, or death within a year?

A) 5%
B) 10%
C) 20%
D) 50%

Kragholm et al. Bystander efforts and 1-year outcomes in out-of-hospital cardiac arrest. New England Journal of Medicine. 2017 May 4;376(18):1737-47.

Outcomes of Inpatient CPR in Elderly

- **Site:** U.S. hospitals, 2009
- **Population:** 430,000 inpatients 65+ who underwent CPR
- **Design:** Observational Study
- **Results:**
  - 18% survival to hospital discharge
  - Among survivors, <40% discharged home

Ehlenbach et al. New England Journal of Medicine. 2009 Jul 2;361(1):22-31.

Outcomes of Invasive Procedures

What percentage of Medicare beneficiaries undergoing femoropopliteal bypass will be alive within 2.7 years?

A) 90%
B) 70%
C) 65%
D) 45%

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Redberg et al. High Mortality Rates in Medicare Patients After Peripheral Artery Disease Revascularization. *JAMA Intern Med.* 2021;181(8):1041–1042.

Outcomes of Feeding Tubes in Dementia

- **Site:** U.S. nursing homes, 2012
- **Population:** 36,492 nursing home residents with dementia and feeding difficulties
- **Design:** Cohort Study
- **Results:**
  - Survival among those receiving a feeding tube no better vs. those not receiving (hazard ratio 1.03, 0.94-1.13)
  - Early insertion doesn't improve survival relative to late insertion (hazard ration 1.01, 0.86-1.20)

Teno et al. Does feeding tube insertion and its timing improve survival? J Am Geriatr Soc. 2012 Oct;60(10):1918-21.

Medication Usage in Older Adults with Co-morbidities

What is the average number of daily prescription medications among older adults with cancer?

A) 3
B) 6
C) 9
D) 12

Outcomes of Invasive Procedures

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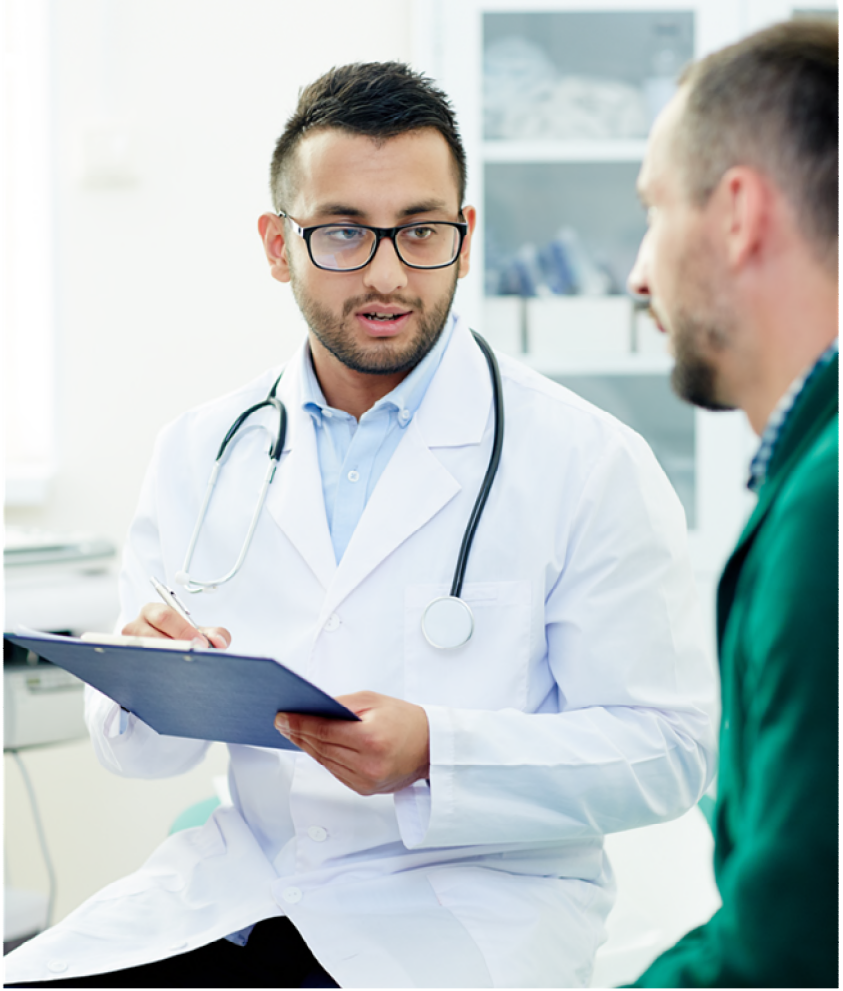
Nightingale et al. Evaluation of a pharmacist-led medication assessment used to identify prevalence of and associations with polypharmacy and potentially inappropriate medication use among ambulatory senior adults with cancer. J Clin Oncol. 2015 May 1;33(13):1453-9.



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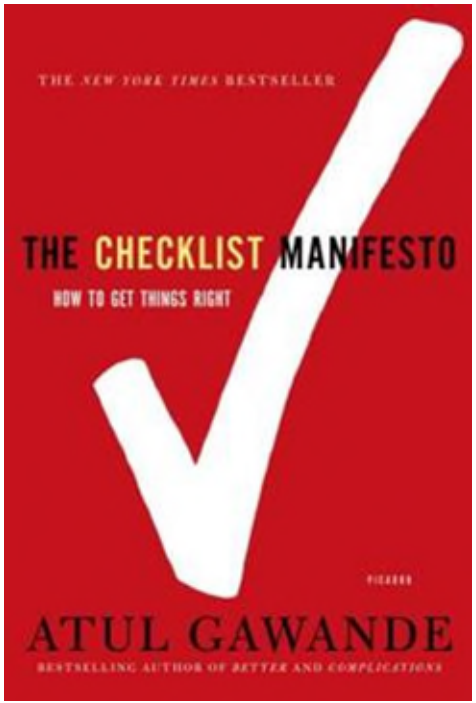
Being Systematic About Advanced Care Planning

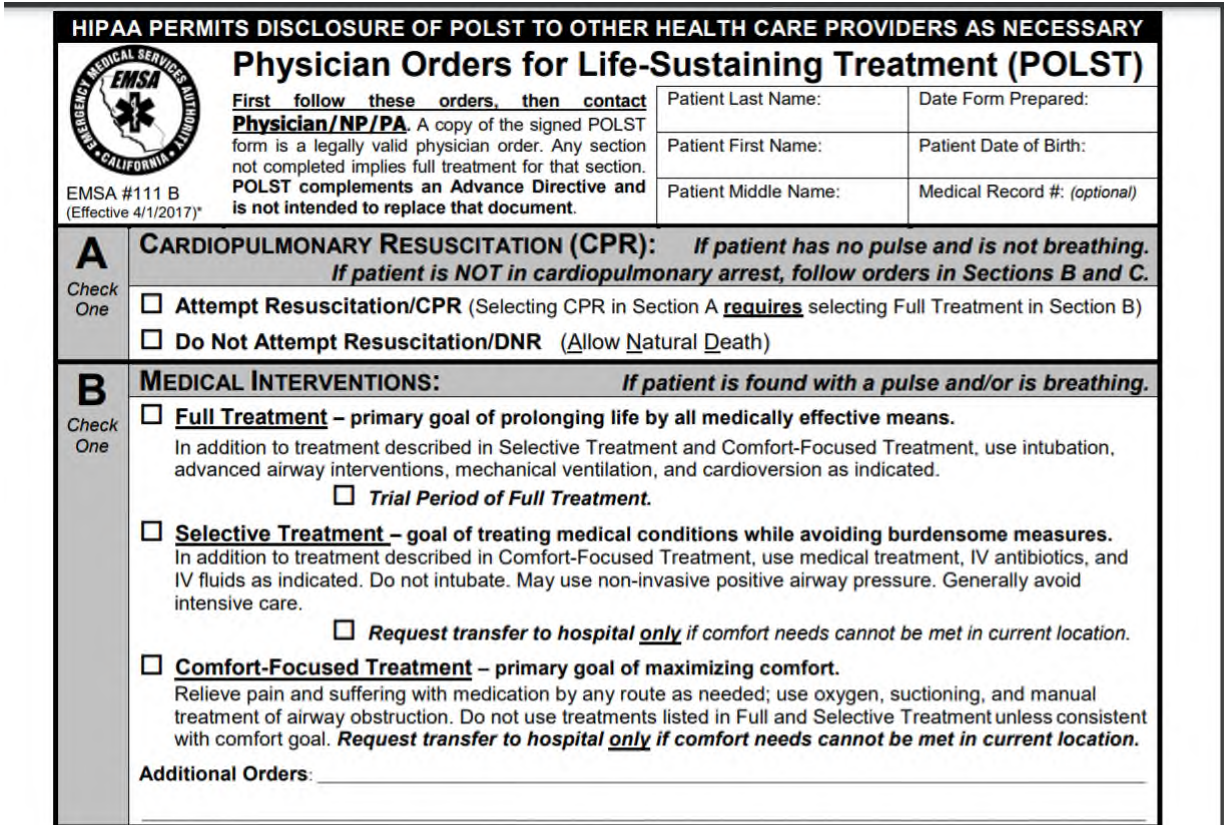


"It's just too easy for an otherwise competent doctor to miss a step, or forget to ask a key question or, in the stress and pressure of the moment, to fail to plan properly for every eventuality…Experts need checklists–literally–written guides that walk them through the key steps in any complex procedure."

Advanced Care Planning Process

✓	Assess Capacity
✓	Care Planning Discussion
✓	Surrogate Decision Makers
✓	Documenting
✓	Advanced Directive Registries

POLST



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

EMSA #111 B
(Effective 4/1/2017)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.***

- ☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)
- ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

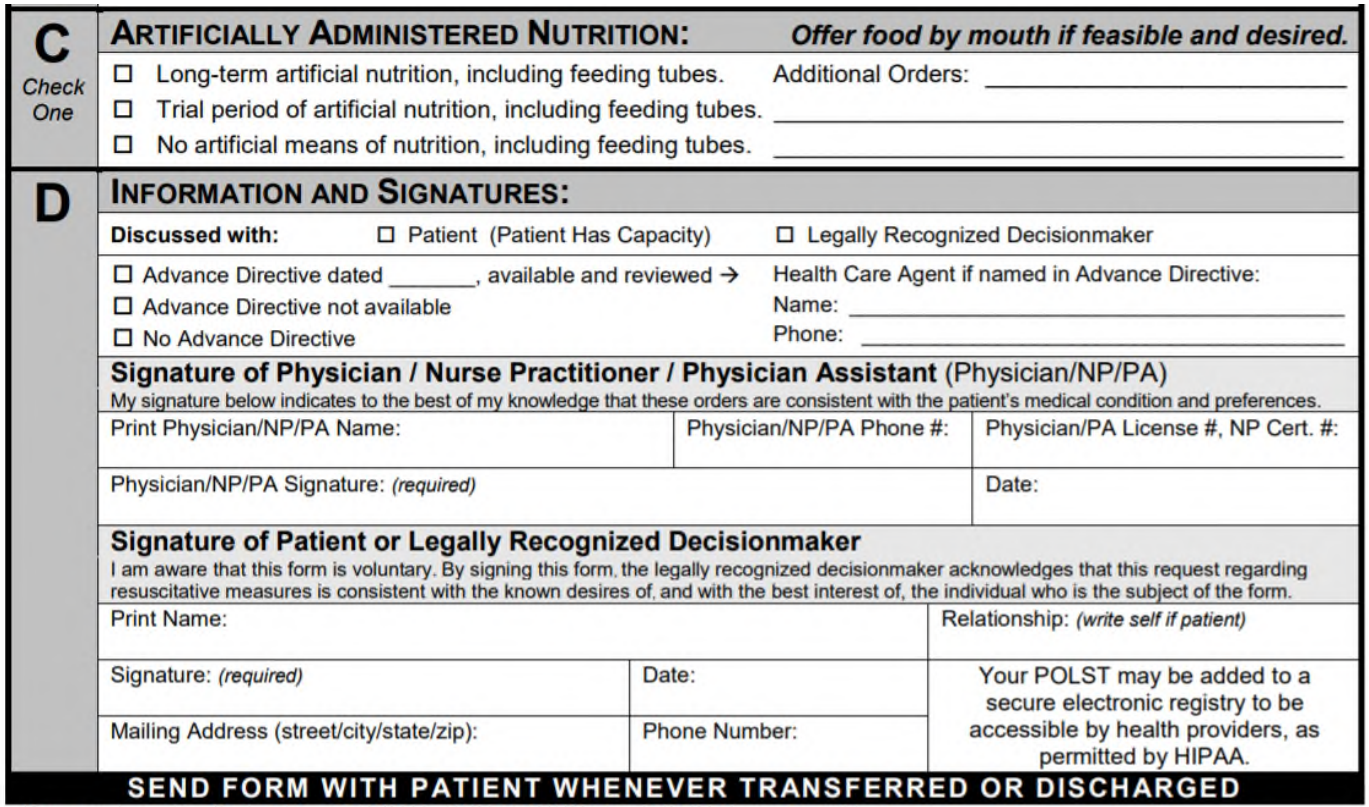
B — *Check One*

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

- ☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
  In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
  - ☐ ***Trial Period of Full Treatment.***
- ☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
  In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***
- ☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
  Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

POLST



C *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

- ☐ Long-term artificial nutrition, including feeding tubes.
- ☐ Trial period of artificial nutrition, including feeding tubes.
- ☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

- ☐ Advance Directive dated _____, available and reviewed →
- ☐ Advance Directive not available
- ☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

Thank You!

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