Overview

• The need for and benefits of advance care planning
• Resources for advance care planning
Life Expectancy

Average U.S. Life Expectancy (both genders)

## Changes in leading causes of death

### Top Three Causes of Death

<table>
<thead>
<tr>
<th></th>
<th>1900</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia &amp; Influenza</td>
<td>Heart disease</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Diarrhea &amp; Enteritis</td>
<td>Chronic Lower Respiratory Disease</td>
<td></td>
</tr>
</tbody>
</table>
Deaths in Acute Care Settings are Down; Intensive Care at the End of Life is Increasing

Change in End-of-Life Care for Medicare Beneficiaries: Site of Death, Place of Care, and Health Care Transitions in 2000, 2005, and 2009
Trajectories of eventually fatal chronic illnesses. Source: Lynn & Adamson, 2003
Why plan?

- 50% of people at the end of life won’t be able to make their own medical decisions

- Healthcare professionals and family are left with uncertainty, stress
Californians Think Planning for Serious Illness and End of Life is Important

Think recording wishes is important 82%

Wishes for care recorded in some form 23%

CHCF 2012 data, The Final Chapter
Most Patients Do Not Discuss End-of-Life Wishes with Family

Have you talked with (the loved one you would want to make decisions on your behalf) about the kind of medical treatment you would want?

- Yes 42%
- No 56%
- Refused 2%

**Most likely to say “yes”**:  
- Age 65+ (71%)
- White (54% vs. 41% African Americans, 31% Latinos, and 33% Asians)
- Some college+ (46% vs. 36% high school or less)
- Income $50K+ (49% vs. 38% <$50K)
- Has chronic conditions (48% vs. 34%)

Source: Californians’ Attitudes Toward End-of-Life Issues, Lake Research Partners, 2011. Statewide Survey of 1,669 adult Californians, including 393 respondents who have lost a loved one in the past 12 months. Copyright 2012, California HealthCare Foundation.
Advance Care Planning: a conversation about...

What is **important** to the individual:
- Hopes, goals and concerns about the future

The **realities** facing the individual:
- Diagnoses, abilities, limitations, resources

**Completing** documents and arrangements
What is an Advance HealthCare Directive?

- Tool to make health care wishes known if unable to communicate

- Allows a person to do either or both of the following:
  - Appoint a surrogate decision maker (Durable Power of Attorney for Health Care)
  - Give instructions for future health care decisions (Living Will)
What goes into an AHCD?

• Healthcare Agent
• Goals
• Values
• Treatment Preferences
• Leeway
Benefits of ACP Discussions: The Patient’s Perspective

• Increases likelihood that wishes will be respected at end of life
• Achieves a sense of control
• Strengthens relationships
• Relieves burdens on loved ones
• Eases sharing of medical information (HIPPA)
• Provides opportunities to address life closure
ACP: What patients need to hear from healthcare professionals

Current state
- Diagnoses
- Threats to wellbeing and function
- Expected trends and outcomes

Treatment options
- Benefits
- Burdens
- Likely results
- Alternatives
Benefits of ACP Discussions: The health system perspective

- Individuals often choose care in the home and community, with lower overall costs
- Fewer hospitalizations
- Lower intensity of care
- Earlier hospice enrollment
- Better quality of life
What healthcare professionals need to hear from patients

**Surrogate**
Who is to speak for the patient if incapacitated

**Treatment wishes**
Such as resuscitation (CPR)

**Values, Goals, Preferences**
What makes life worth living
What needs to be completed before death
What is unacceptable to the patient

“I’d rather die in comfort than ______.”

Special religious or cultural preferences
Advance Care Planning Documents

California Advance Health Care Directive

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

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.
ACP across the continuum

Age 18
- Complete an Advance Directive
- Update Advance Directive Periodically
- Diagnosed with Serious or Chronic, Progressive Illness (at any age)
- Complete a POLST Form
- Treatment Wishes Honored

CCCC perspective on Advance Care Planning
POLST
Physician Orders for Life-Sustaining Treatment

- Physician’s Medical Order
- Provides instructions regarding specific medical treatment
- Legally binding across healthcare sites in California
- Valid only if appropriately signed
Indications for a POLST Form

- Serious illness
- Medically frail
- Chronic progressive condition
<table>
<thead>
<tr>
<th>AHCD</th>
<th>POLST</th>
</tr>
</thead>
<tbody>
<tr>
<td>• General instructions for FUTURE CARE</td>
<td>• Specific orders for CURRENT CARE</td>
</tr>
<tr>
<td>• Requires interpretation</td>
<td></td>
</tr>
<tr>
<td>• Needs to be retrieved</td>
<td>• Stays with the patient</td>
</tr>
<tr>
<td>• Many different forms</td>
<td>• Single, standardized form</td>
</tr>
<tr>
<td>• Signed by patient, witnesses</td>
<td>• Signed by patient (or HC Agent) and physician</td>
</tr>
</tbody>
</table>
What Is Our Goal?

- Wishes Explored
- Wishes Expressed
- Wishes Honored
What We Need to Get There

COMPETENT COMMUNITIES

COMPETENT PROFESSIONALS

COMPETENT SYSTEMS

PUBLIC POLICY & COMMON VISION

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA
Effective Communities
Resources for Creating Effective Communities

Local Coalitions

POLST & Advance Care Planning Training in advance care planning

Faith Leader Outreach

Social Media
PALLIATIVE CARE WEBINAR SERIES

Soothing the Spirit
Providing Spiritual Care to Palliative Care Patients

Thursday, June 17, 2015
Noon to 1 p.m. PDT

FEATURING
Rev. Susan Cosio, MDiv, BCC
Sutter Medical Center

Webinar focuses on spiritual issues commonly faced by patients with serious illness

FOR HEALTHCARE PROVIDERS
Resources for healthcare professionals on informed decision-making, palliative medicine and end-of-life care

FOR PATIENTS & LOVED ONES
Helping patients and loved ones discuss and document wishes for medical care

Advance Care Planning
Making decisions about the care you want if you become unable to speak for yourself

GET INVOLVED
Education

COALITIONCCC.ORG
ADVANCE CARE PLANNING RESOURCES

Talking About Advance Care Planning

While sudden changes in your life, such as you or a loved one being involved in an accident or becoming seriously ill, can be hard to prepare for emotionally, there are ways to ensure that you receive the type of compassionate care you want — when you need it most.

The Coalition for Compassionate Care of California (CCCC) encourages you to talk to your loved ones now about your wishes for medical care and treatment in the event that you are unable to speak for yourself. Planning ahead for future medical needs is the best way to ensure that your wishes will be respected.

Take Note: Change in law may affect advance directives notarized after Jan. 1, 2015

If you're not sure how to have these difficult conversations, don't know where to begin or what form to use, here are some resources that can assist you:

Resources

- Talking About Advance Care Planning
- Group Discussion Guide
- Advance Directive Forms
- Healthcare Agents Or Surrogate Decision Makers
- Resources For Healthcare Providers
Public Engagement Initiative

• One year pilot project
• 9 Local coalitions
• Ranging from 10 to nearly 100 members

✓ Alameda/Contra Costa
✓ Orange
✓ Riverside
✓ Santa Cruz
✓ Sonoma
✓ Journey Project/Sonoma
✓ Monterey
✓ CACCC
✓ West Los Angeles
Local coalition members represented:

- hospices
- hospital systems
- medical groups
- senior organizations
- county health agencies, and
- faith communities.
ACP Facilitator Trainings

- CCCC trained 21 coalition members as ACP facilitator trainers
- Coalition members in turn trained more than 400 community members as ACP champions and/or coaches
ACP Community Outreach

- Local coalitions hosted more than 160 events
- Attended by more than 3,100 people
Effective Professionals

EFFECTIVE PROFESSIONALS
Resources for “The Conversation”

CoalitionCCC.org
Resources for Creating Effective Professionals

Interactive training
- Skill development
- Communication
Education for Professionals

Regular Offerings
- POLST
- Advance Care Planning
- Diversity and Cultural Sensitivity

Monthly Webinars
- Palliative Care, Public Policy, and More

Online Course
- Working with POLST for Professionals
Bringing Training to You

Recent trainees:
Effective Systems
Resources for Creating Effective Systems

• POLST Form
• POLST Registry
• Resources
• Consultation Service
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. 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.

<table>
<thead>
<tr>
<th>Patient Last Name:</th>
<th>Date Form Prepared:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient First Name:</td>
<td>Patient Date of Birth:</td>
</tr>
<tr>
<td>Patient Middle Name:</td>
<td>Medical Record #: (optional)</td>
</tr>
</tbody>
</table>

A CARDIOPULMONARY RESUSCITATION (CPR):
- If patient has no pulse and is not breathing, follow orders in Sections B and C.
- If patient is found with a pulse and/or is breathing, 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 MEDICAL INTERVENTIONS:
- Full Treatment – primary goal of prolonging life by all medically effective means.
- Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.
- Comfort-Focused Treatment – primary goal of maximizing comfort.

In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardiovascular as indicated.

☐ Full Period of Full Treatment.

☐ Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.

☐ Comfort-Focused Treatment – primary goal of maximizing comfort.

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.

Additional Orders:

C 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:

☐ Patient (Patient Has Capacity)
☐ Legally Recognized Decisionmaker

☐ Advance Directive dated __________ available and reviewed

☐ Advance Directive not available

☐ No Advance Directive

Healthcare Agent if named in Advance Directive:

Name:

Phone:

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 Name:__________________________

Physician Phone Number:________________________

Physician License Number:________________________

Physician Signature: ____________________________

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 patient who is the subject of the form.

Print Name:________________________

Relationship: (write self if patient)

Signature: ____________________________

Date:________________________

Mailing Address (street/city/state/zip):________________________

Phone Number:________________________

Office Use Only:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid.*
POLST = Physician Orders for Life-Sustaining Treatment

Key Facts About POLST for Residents and Family Members

The POLST form is a written order from the physician that helps give people or those with serious health conditions more control over their own care. It can help you get the care you want, and also to protect you from getting medical treatments you DO NOT want.

- The POLST is voluntary. Nursing homes may include the POLST in their admission documents, but you are not required to complete a POLST form if you do not wish to.

- Don’t complete the form until you’ve had an in-depth discussion. Before filling out the POLST form, you should have an in-depth discussion with your physician or someone trained to discuss the POLST form. This conversation is very important and will address your overall health, your health care wishes and goals for your care. It is very helpful to include your family members in the conversation, even if they are not your designated decision-maker, so they understand your condition and are aware of your treatment wishes.

- The POLST form is not valid until it is signed by both you (or your designated decision-maker) and your physician.

- A POLST form does NOT replace an advance directive. An advance directive is still the best way to appoint a legal healthcare decision-maker, and is recommended for all adults, regardless of your age or current health. A POLST works together with your advance directive, providing more specific detail regarding care wishes and goals of care.

- The original bright pink form travels with you to different settings – home, assisted living, nursing facility or hospital. If you go home or to another care setting, the original pink form should go with you, and be kept in an easy to access place.

- You only have to complete a new POLST if your treatment wishes change. You do not need to fill out a new POLST if you move from one facility to another, or change doctors.

- Because the POLST form is a physician order, emergency medical personnel are required to adhere to its instructions regarding CPR and other emergency medical care. The POLST form is printed on bright pink paper so it will be easily recognizable by all health care personnel.

- You can request different treatment or void the POLST form, at any time. To change your POLST instructions, complete a new POLST form and have your doctor sign it. To void the form, draw a line through sections A through D, write “VOID” in large letters, then sign and date the line.

Please go to: http://www.capolst.org or call (916) 409-2222 for more information.

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POLST Registry

- Existing POLST Forms
  - Convert to eFORM by Care Givers or by Registry Organization
  - Preferably before Pilot

- Submit paper POLST Form or Fax
  - Convert to eFORM by Registry Organization

- Patient or Care Provider
  - Submit eFORM

- Patient or Care Provider (Preferred Method)

- HIE Registry or other Electronic Records
  - Extract, translate and Load Process

- Registry Organization
  - Phone Inquiries
  - Monthly Report

- With QR Code Scanner
- Without QR Code Scanner

Coalition for Compassionate Care of California
Ethnographic Research

Gather Round:
Understanding How Culture Frames End-of-Life Choices for Patient and Families
Diversity Training & Resources

- Shared decision-making
- Developmental disabilities
- Multilingual resources
Resources for Making the Case

Value Snapshots

CoalitionCCC.org/valuesnapshots
Consultation Service

Recent clients:

UCLA Health

[Seal of Sonoma County]