Objectives

- Discuss components for an advance care planning program.
- Outline changes with aging that are integrated into advance care planning discussions.
- Describe actual examples of conversations with older adults as they contemplate end of life.
27. Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits, its risks, side-effects, consequences, and cost, and any reasonable and morally legitimate alternatives, including no treatment at all.

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.

What is OSF Care Decisions?
OSF Care Decisions is:

An Advance Care Planning (ACP) model developed by OSF, that uses trained facilitators to help patients and their families plan for health care decisions they may need to make in the future.

Advance Care Planning

“Patients have the moral and legal right to determine what will be done with their own person; to be given accurate, complete, and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens, and available options in their treatment and to be given the necessary support during the decision-making and treatment process.”

ANA Code of Ethics for Nurses with Interpretive Statements (2001)

OSF Care Decisions: Advance Care Planning Model

Goal: Care Decisions advance care planning will be integrated into daily patient care in all settings across the OSF continuum of care.

FY 2009
- Care Decisions model pilot project
- Respecting Choices® Gunderson Lutheran program

FY 2010
- 136 Care Decisions system facilitators trained
- Over 1000 patient discussions
- Over 150 OSF employee discussions
OSF Care Decisions: Advance Care Planning Model

FY 2011
- Increase patient and employee education
- Multiply number of patient and employee discussions
- Add facilitators to sites where OSF care provided
- Refine electronic medical record integration

Future Goals
- Measure Advance Care Planning outcomes
- Focus on community education

Care Decisions Facilitators
- OSF nurse, social worker, ethicist, chaplain, parish nurse, physician, or mid-level provider
- Completed pre-coursework and 8 hour class
- Complete 10 ACP’s per year
- Use Care Decisions model and materials
- Available in OSFMG, Rockford Cardiology, Neurosciences Institute, Center for Cancer Care, the hospital and home care/hospice settings

Care Decision Materials
Patient and Family Education
Care Decision Materials

Information
- CPR
- Feeding Tubes

Discussion Form
- Cover Sheet
- Facilitator Log

Advance Directives

Legal documents designed to guide care when a person can no longer speak for themselves.
- Power of Attorney for Health Care Form
- Living Will
- POLST
- DNR order

Power of Attorney for Health Care

- Allows a person to appoint an agent to speak for them if they can no longer speak for themselves
- Best completed after Advance Care Planning
- Can be revoked or changed at any time
- Should be discussed with family and providers
- Will be honored in any state
Advance Directive: The Form Alone Does Not:

- Encourage a patient to reflect on their values and beliefs and how they may impact future care decisions
- Engage the patient to have a conversation with family, friends, and their providers about their wishes for end of life care and choose a trusted agent
- Encourage a patient to understand their current health status and the benefits and burdens of possible future care decisions

OSF Care Decisions

- Conversation is *Paramount*
- Tailored to patient's health condition
- Assists patient to consider future health care decisions
- Provides an opportunity to share preferences with family and provider
- Supports patient's own wishes and values.

OSF Care Decisions

- Encourages participation designated agent
- Provides support information for decision making
- Completion of Power of Attorney for Healthcare
- Creates a record of conversation
- Available in Electronic Health Record
## Elements of Advance Care Planning Discussions with the Older Adult

- Generational issues
- Loss of function/burden
- Addressing their particular illness(es) and understanding chronic illness trajectory
- Understanding treatment options
- Hopes and goals

## Generational Issues

- Physician Interaction
- “My family knows what I want.”
- Strong Work Ethic
- Leaving a Legacy
- Coming to Grips with their Mortality

## Losses and Burden

- Functional Loss
- Family/Friend Loss
- Financial Burden
- Long term Care
Understanding Their Illness

- Hear their Story
  - Been POAH for someone else
  - Prior Hospitalizations/intubation
- Query their Understanding
- Tailor discussion to them personally
  - Avoid too much information vs. oversimplification

Understanding Treatment Options

- Value of CPR
- DNR does NOT = Do not Treat.
- What entails life support (Ventilator, feeding tubes, pressors, dialysis)
- Palliative radiation/chemotherapy

Hopes and Goals

- Their definition of Quality of Life
- Spiritual/Cultural Needs at End of Life
- What brings them peace/comfort
- Where they want to die
- Understanding Symptom Management
- Hospice Option
Conversations: Charlotte
- End Stage Heart Failure
- Age: 94
- POAHC: Friend
  - Revised to son

Conversations: Tia
- Acute Myelogenous Leukemia (AML)
- Age: 77
- POAHC: Daughter

Conversations: Frank
- COPD/ Lung CA
- Age: 68
- POAHC: Wife
Conversations: Lois
- Failure to Thrive
- Age: 89
- POAHC: Daughter

Conversations: Conrad
- End Stage Renal Failure
- Age: 80’s
- POAHC: Friend/Neighbor

Conversations: Otis
- Dementia
- Age: 85
- POAHC: Spouse
Objectives

- Discuss component for an advance care planning program
- Outline changes with aging that are integrated into advance care planning discussions
- Describe actual examples of conversations with older adults as they contemplate end of life

References


Questions? Comments?

Thank you!