



**SANTA CLARA
VALLEY MEDICAL CENTER**
Hospital & Clinics



Life is a Journey: Plan Ahead!

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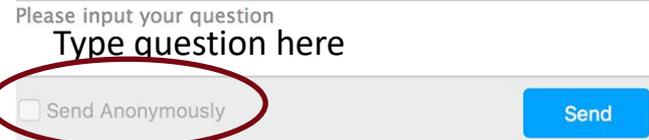
Co-hosted by:

Dr. Grant Smith MD and Claire Bleymaier RN MPH,
Stanford's Palliative Care Health Education, Engagement, and
Promotion program

Quick Intro to a ZOOM Webinar

To ask a question:

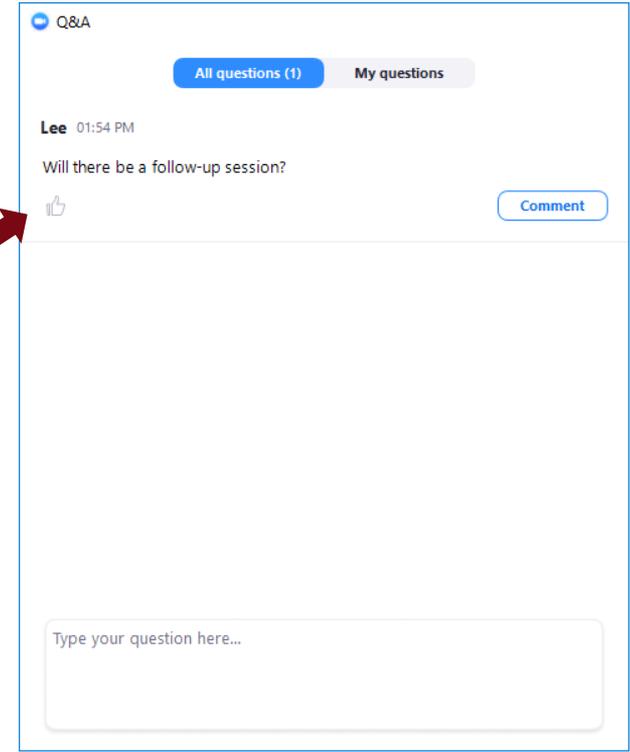
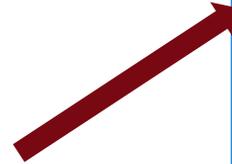
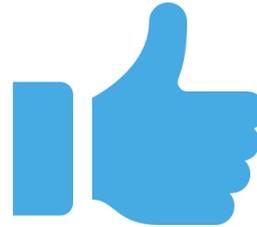
- Click on the “Q&A” box
- Type your question and click “Send”
- Can ‘send anonymously’ by checking that box
- We will **not** be using the “Chat” or “Raise Hand” tools



Quick Intro to a ZOOM Webinar

Once there are questions:

- You can “Like” questions, by clicking the “Thumb Up” icon
- This will help us answer the most popular questions first



Objectives today

- Educate
- Engage
- Embolden

Roadmap

- **Getting to know each other**
- What is Advance Care Planning?
- Why think about this now?
- Where do I start?



Photo by [Sebastien Gabriel](#) on [Unsplash](#)

Getting to Know Each Other

- Why am I here?



Akiromaru / iStock/Getty Images Plus

?

Guessing sucks!

“If I should suffer a serious disease, injury or illness, I desire that those who love and care for me touch me and tell me so, demonstrating that I am precious to them.”

Getting to Know Each Other



- What brought you here today?

Today is National Healthcare Decisions Day!

“my vision of demystifying advance care planning and ensuring that it becomes a routine part of everyone’s lives and healthcare experiences”

nhdd@ihi.org

[@NHDD](https://twitter.com/NHDD) on Twitter

[National Healthcare Decisions Day](https://www.facebook.com/NHDD) on Facebook



- <https://www.wallerlaw.com/our-people/382/Nathan-Kottkamp>

Defining Palliative Care

- Palliative care is specialized health care for **people living with a serious illness.**
- This type of care is focused on **providing relief from the symptoms and stress of the illness.**
- The goal is to **improve quality of life** for both the **patient and the family.**

Defining Palliative Care

- Provided by a specially-trained **team**, palliative care specialists work together with a patient's other doctors to **provide an extra layer of support**.
- Palliative care is based on the **needs** of the patient, not on the prognosis. It is appropriate **at any age and at any point in a serious illness** and **can be delivered alongside curative treatment**.

Palliative Care

Hospice

Roadmap

- Getting to know each other
- **What is Advance Care Planning?**
- Why think about this now?
- Where do I start?



What is Advance Care Planning?



- Advance care planning is **making decisions** about the health care you would want to receive **if you become unable to speak for yourself**.
- These are **your decisions to make**, regardless of what you choose for your care.
- The decisions are **based on your personal values**, preferences, and discussions with your loved ones.

National Hospice and Palliative Care Organization, 2019

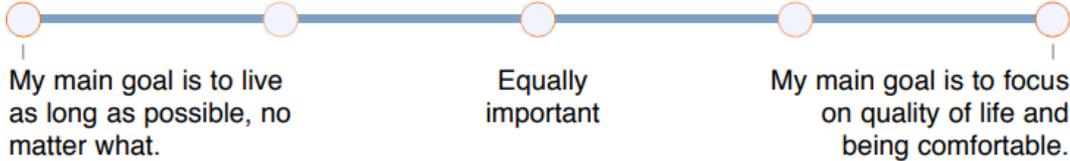
What Type of Decisions Should We Think About?

- **Who** would you want to make decisions for you if you were unable to communicate?
- **What** makes life worth living given your current health status?
- What would be **important** to you if you were seriously ill or even at the end of your life?



TODAY, IN YOUR CURRENT HEALTH

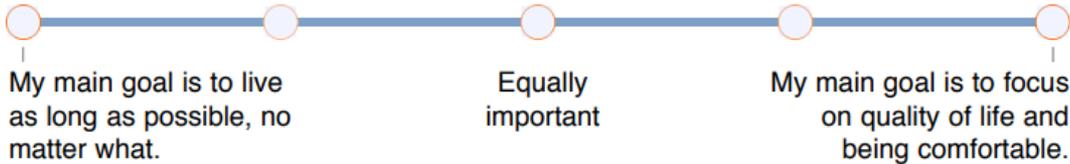
Check one choice along this line to show how you feel today, in your current health.



If you want, you can write why you feel this way.

AT THE END OF LIFE

Check one choice along this line to show how you would feel if you were so sick that you may die soon.



If you want, you can write why you feel this way.

What Type of Decisions Should We Think About?



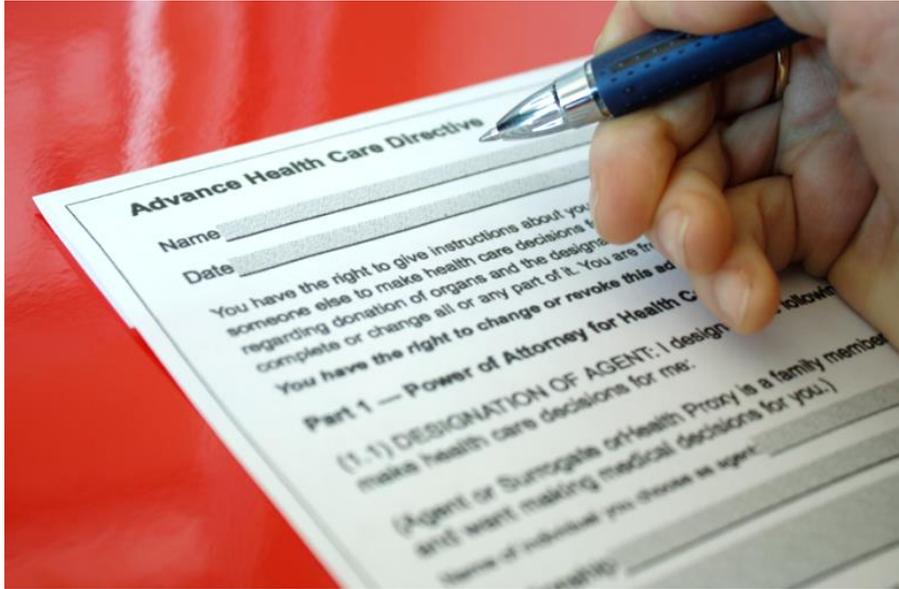
- Are there limitations you would put on life-prolonging treatment?
- Would you want to receive cardiopulmonary resuscitation or be placed on a breathing machine?

Survivable vs. Livable

“The Tree of Life”



Definitions



- **Advance Directive (AD)/Living Will:**
 - A written document that helps you tell doctors (and your loved ones) how you want to be treated if you cannot speak for yourself.
 - Consider what treatments you would (or would not) want.

Definitions

- **Durable Power of Attorney for Health Care (DPOA)/Health Care Proxy (HCP)/Surrogate Decision Maker:**
 - Names someone to make medical decisions for you at a time when you are unable to do so.
 - This person should be familiar with your values and wishes.



National Institute on Aging, 2019

Definitions



- **Do not resuscitate/Do not intubate (DNR/DNI):**
 - A physician order placed **in** the hospital
 - Would not want CPR (cardiopulmonary resuscitation) or other life-support measures (such as a breathing machine).

Adapted from National Institute on Aging, 2019

Definitions

- Physician Orders for Life-Sustaining Treatment (POLST):**
 - A physician order **outside** of the hospital.
 - Types of interventions healthcare professionals would take outside of the hospital.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY			
 <p>EMSA #111 B (Effective 1/1/2015)*</p>	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): <i>If patient has no pulse and is not breathing.</i> <i>If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i>		
	<input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR in Section A <u>requires</u> selecting Full Treatment in Section B) <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (Allow <u>N</u> atural <u>D</u> eath)		
B Check One	MEDICAL INTERVENTIONS: <i>If patient is found with a pulse and/or is breathing.</i>		
	<input type="checkbox"/> 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. <ul style="list-style-type: none"> <input type="checkbox"/> Trial Period of Full Treatment. <input type="checkbox"/> 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.		

Adapted from National Institute on Aging, 2019

Roadmap

- Getting to know each other
- What is Advance Care Planning?
- **Why think about this now?**
- Where do I start?



"It's always too early, until
it's too late"

-The Conversation Project, 2013

"arah shure we'll cross
that bridge when we come
to it"

-most people I know.

Most people agree that this is important

- **90%** say **talking to your loved ones about end of life** care is important
 - Only **27%** have actually done so
- **60%** say that making sure their **family is not burdened by tough decisions** is “extremely important”
 - But **56% have not communicated** their end of life wishes
- **82%** say it’s important to put their **wishes in writing**
 - Only **23%** have actually done it



Sources: CDC, Conversation Project National Survey (2013), Survey by the California Healthcare Foundation (2012)

Most people need help with decision-making



- **40% of all hospitalized patients are incapable of making their own treatment decisions**
- **70% of decedents age 60 and older at death faced treatment decisions in the final days of life and were incapable of participating** in these decisions.

Raymont (2004) Lancet
Silveira (2010) NEJM





Does any of this make a difference?

- If patients had advance care planning conversations:
 - More likely to have their **wishes known and followed** (Detering et al. 2010; Houbin 2014)
 - **Family members** are **more** likely to be **satisfied** with the quality of death (Detering et al. 2010)
 - **Less likely to receive intense interventions** (mechanical ventilation, CPR, die in ICU, use feeding tube) (Zhang et al. 2009, Teno et al 2008, Wright et al. 2008, Brinkman-Stoppelenberg 2014)
 - **More likely** to receive outpatient **hospice** and be referred to **hospice earlier** (Zhang et al. 2009, Wright et al. 2008)

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- **Where do I start?**



Photo by [Sebastien Gabriel](#) on [Unsplash](#)

Talk with your doctor

- People make different decisions depending on their health status
- Don't be afraid to ask your health care providers(s)



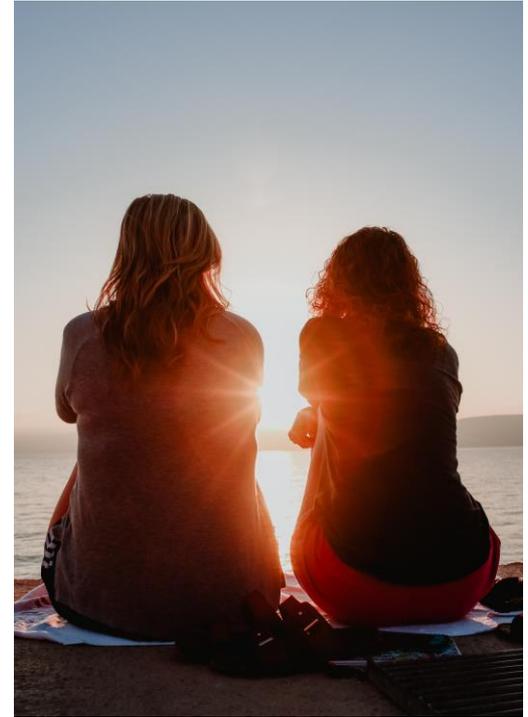
Think about what matters most



- Consider hopes, goals, priorities, values
- Consider worries, fears
- Consider tradeoffs
 - What can you not live without?
- Uncertainty is OK

Choose a Health Care Proxy

- It's impossible to think through every scenario
- What makes a good surrogate decision maker:
 - Adult
 - Agreeable
 - Available
 - Acquainted
 - Advocate



Complete an Advance Directive

California Advance Health Care Directive

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

Part 1 Choose a medical decision maker, Page 3

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself. This person will be your advocate. They are also called a health care agent, proxy, or surrogate.



Part 2 Make your own health care choices, Page 7

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 not able to tell them yourself.

Part 3 Sign the form, Page 13

The form must be signed before it can be used.



Think ahead
Speak for Yourself

My form
Name: _____

Think Talk Tell Record Review

- Putting some thoughts in writing can be helpful
- PREPARE For Your Care [USA]
 - <https://prepareforyourcare.org>
- Think Ahead [Ireland]
 - https://hospicefoundation.ie/wp-content/uploads/2021/02/Think_Ahead_Editable.pdf

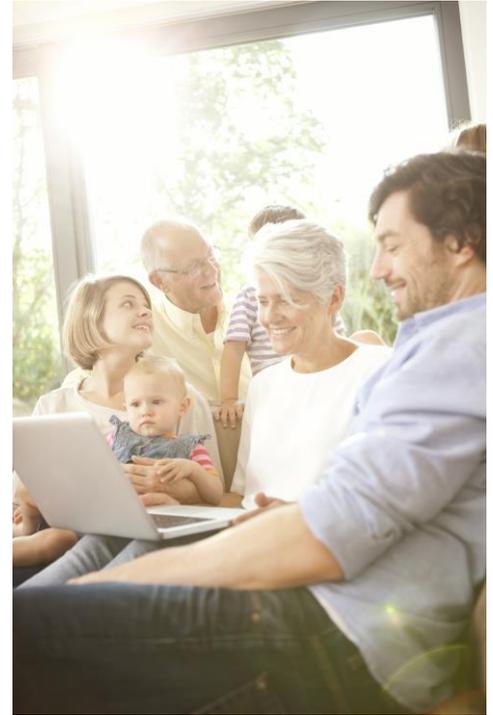
Additional Resources

- The Conversation Project
 - <https://theconversationproject.org>
- CODA alliance/ Go Wish Cards
 - <https://codaalliance.org/go-wish/>
- 5 Wishes
 - <https://fivewishes.org/>
- Stanford Palliative Care Advance Care Planning Website
 - www.med.stanford.edu/palliative-care



Practical Advice for Preparing for Serious Illness

- Set up a Video Chat app with your loved ones
- Plan for Medications – keep a list, keep a supply, call clinic early if need refills
- Plan for Pets – who could care for them if needed
- Plan for Money/Bills – who could help manage money if needed
- Plan for a Hospital Visit – Bring any advance directives/POLST, phone numbers for emergency contacts; bring glasses/hearing aids/dentures/mobility devices



How Do I Get Palliative Care at SCVMC?

- You can ask your doctor to place a referral
- Location in Valley Specialty Center, Bascom Ave, San Jose
 - TeleHealth also available!



How Do I Get Palliative Care at Stanford?

- You can refer yourself
 - Call our clinic at (650) 724-0385
 - Website:
<http://med.stanford.edu/palliative-care.html>
- You can ask your doctor to place a referral
- Locations in Palo Alto, South Bay, and Emeryville
 - TeleHealth also available!



Over to you...

- What are YOUR next steps?





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Thank you!

REMEMBER:



Knowing wishes → Honouring choices