Life is a Journey: Plan Ahead!

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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?
Getting to Know Each Other

- Why am I here?
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 on Twitter
National Healthcare Decisions Day 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.

Center to Advance Palliative Care (CAPC), 2019
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.

My main goal is to live as long as possible, no matter what.  Equally important  My main goal is to focus on quality of life and being comfortable.

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.

My main goal is to live as long as possible, no matter what.  Equally important  My main goal is to focus on quality of life and being comfortable.

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”

Health Care Decisions

What Makes Life Worth Living

Health Status
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.
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.

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

**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.

<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 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.

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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)
  - More likely to receive outpatient hospice and be referred to hospice earlier (Zhang et al. 2009, Wright et al. 2008)
Roadmap

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

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

REMEMBER:

Knowing wishes → Honouring choices

www.med.stanford.edu/palliative-care

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