Conversations of a Lifetime

Local initiative to create a conversation ready community
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Project Administrator
Hospice of Cincinnati

The aim is to increase the number of Advance Care Planning (ACP) and end of life planning conversations and related satisfaction among patients, families and providers by end of 2016.

What is Advance Care Planning?

Advance Care Planning is a series of conversations to discuss and understand your end-of life care wishes, and to document those wishes, to provide a shared understanding of what matters most, and to make decisions easier when the time comes.

It’s about the conversation
Wisconsin Medical Society video

Talking about end-of-life

We’ve Had the Conversation. Have You?

CONSIDER THE FACTS
90% of people say that talking with their loved ones about end-of-life care is important.
27% have actually done so.

The burden of decisions

We’ve Had the Conversation. Have You?

CONSIDER THE FACTS
60% of people say that making sure their family is not burdened by tough decisions is “extremely important.”
56% have not communicated their end-of-life wishes.
Talking to our doctors

We’ve Had the Conversation. Have You?

start your conversation today »

CONSIDER
THE FACTS

80% of people say that if seriously ill, they would want to talk to their doctor about end-of-life care

7% report having had an end-of-life conversation with their doctor

What are Advance Directives?

Advance Directives

• A general term
• Gives instructions about future care if you are unable to participate in medical decisions due to serious illness or incapacity
  – Living Will
  – Medical Power of Attorney

Living Will

• A type of advance directive in which you write down your wishes about medical treatment should you be at the end of life and unable to communicate.

Medical POA

• Names someone else to make decisions about your medical care if you are unable to speak for yourself
  – Healthcare proxy
  – Durable POA
• The person named may be called:
  – Healthcare agent
  – Surrogate or proxy
  – Attorney-in-fact

Palliative and Hospice Care

Palliative Care may be offered at the same time as curative and healing treatments. You do not need to have a terminal illness. Palliative care focuses on quality of life by predicting, preventing, and treating pain and distress. Available from beginning of any illness to the end of life, the focus is on the whole person and family needs from physical, emotional, spiritual and social aspects of care.

A form of palliative care that provides aggressive symptom management at the end-of-life. To enroll a patient in hospice, two doctors certify the patient has 6 months or less to live, should the illness take its natural course. The patient also opts out of aggressive curative treatments that are generally no longer helpful. Patient and family goals are focused on comfort and aggressive symptom management to improve the patient’s quality of life while maintaining independence and creating moments of joy.

Status of surrounding states

Kentucky MOST—Medical Order for Scope of Treatment

Status: Developing
  • March 2014: Kentucky House passed legislation
  • March 2015: Senate passed—sent to Governor for signature
  http://www.lrc.ky.gov/record/14RS/HB145.htm

Indiana POST—Physician Orders for Scope of Treatment

Status: Endorsed
  • May 2013: signed into law
  • July 1, 2013: legally valid throughout state
  http://www.inanapost.org/

MOLST (medical orders for life sustaining treatment) in Ohio— a community standard, not yet legislated

In Ohio, must be paired with an OH DNR CC or CC arrest form

MOLEST / POST Medical Orders for Life Sustaining Treatment in Ohio

Status: Endorsed

• May 2013: signed into law
• July 1, 2013: legally valid throughout state
http://www.indianapost.org/

“Would I be surprised if this person died in the next 12 months?”

Curative Treatment

Advance Directives

• Medical Power of Attorney
• Living Will

Palliative Treatment

Advance Care Planning

• MOLST / POST Medical Orders for Life Sustaining Treatment

Healthy or with reversible illness

Chronic Illness

Terminally Ill or Frail Elderly

MOLST / POST
Stages of advance care planning over the lifetime of adults

**First Steps®**
Create Healthcare POA and consider when a serious neurological injury would change goals of treatment
- Healthy adults who have not planned

**Next Steps®**
Determine what goals of treatment should be followed if complications result in "bad" outcomes
- Adults with progressive, life-limiting illness, suffering frequent complications

**Last Steps®**
Establish a specific plan of care expressed in medical orders using MOLST
- Adults whom it would not be a surprise if they died in the next 12 months

Source: Respecting Choices®

How often should we have the conversation?

*Use these triggers to start the conversation*

<table>
<thead>
<tr>
<th>The 5 Ds</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEATH</td>
<td>Death of a friend or family member</td>
</tr>
<tr>
<td>DIVORCE</td>
<td>Choose another proxy and redo ADs</td>
</tr>
<tr>
<td>DIAGNOSIS</td>
<td>Diagnosis of a significant medical condition, a chronic or terminal illness</td>
</tr>
<tr>
<td>DECAY</td>
<td>It’s been 10 years since the last talk</td>
</tr>
<tr>
<td>DECISION</td>
<td>Decline in physical or mental condition</td>
</tr>
</tbody>
</table>

ABC News-Conversation Project

**Part 1**

Advance care planning is a part of good health care for anyone over age 18.

- We want all of our patients to have these conversations, no matter their health status. Anyone can have an accident.
- It is important for you to consider what decisions you would make if you were unable to speak for yourself due to injuries or a serious illness.
- It is also important for your family and health care team to understand what you want.

Values worksheet

<table>
<thead>
<tr>
<th>How important is to you the following items?</th>
<th>strongly important</th>
<th>moderately important</th>
<th>not important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living near family</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining my independence</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Following my spiritual beliefs and traditions</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living as long as possible, regardless of quality of life</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
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</table>
Do I need a lawyer to fill out any of these forms?

- No. Patients can complete the Living Will and Health Care Power of Attorney forms themselves. Once completed, the forms should be witnessed or signed in front of a notary.
- Signing them in front of the proper witnesses or notary makes them legal.
- You may want to ask for assistance or review with a lawyer as part of estate planning, but you do not have to.
- MOLST form must be completed in a medical setting and signed by a Physician/PA/ APRN

Will another state honor my Advance Directives?

- Laws regarding advance directives differ from state to state but generally, your expressed wishes will be honored.
- If you regularly spend time in another state, you may wish to document your wishes on that state’s form as well.
Points to Remember

• Be patient. Some people may need a little more time to think.
• You don’t have to steer the conversation; just let it happen.
• Don’t judge. A “good” death means different things to different people.
• Nothing is set in stone. You can always change your minds as circumstances shift.
• Every attempt at the conversation is valuable.
• This is the first of many conversations—you don’t have to cover everyone or everything right now.

Thank you for your time!

Questions??