

Advance Care Planning Done Right

Dr. Eric Anderson
Allina Palliative Care Medical Director

Sandy Schellinger, NP
Advance Care Planning
Program Development Manager

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Listen to Your Heart



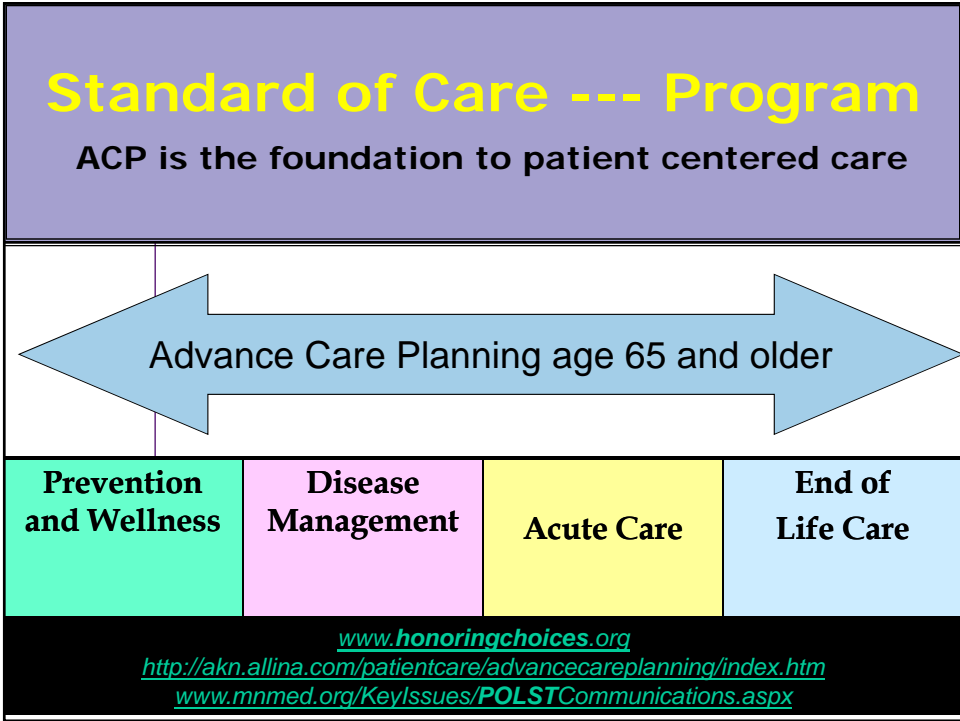
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Advance Care Planning

Objectives:

- **Describe the difference between an advance directive and advance care planning**
- **Identify the disease specific advance care planning needs for heart failure patient**
- **Describe the specific advance care planning roles and responsibilities of the health professional**



ADVANCE CARE PLANNING

Definition of Terms

- **Advance Directive:** living will, health care directive, POLST, written narrative.
- **Advance Care Planning:** the process of discussing, exploring and clarifying an individual's goals, values and treatment preferences.
- **Advance Care Plan:** sum of an individual's documented advance care planning discussions and scanned advance directive document.

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 Advance Care Planning

***For ACP to make a difference...
Advance Care Planning Commitment***

- **Initiate ACP before a medical crisis**
- **Assist patients with an individualized plan**
- **Assure plans are complete and clear**
- **Make plans available to all who participate in decision making**
- **Follow the plans to respect the values and preferences of the patient**



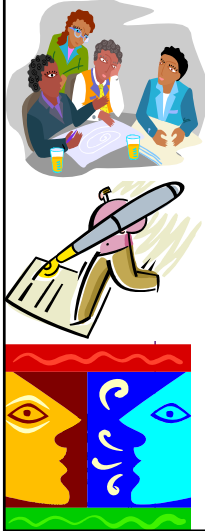
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Advance Care Planning is not ...

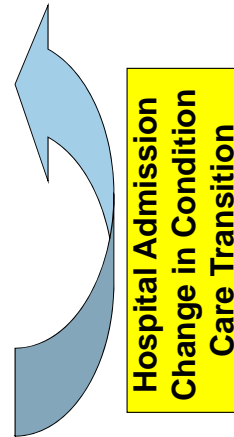
- **Just the completion of a health care directive or living will**



Advance Care Planning is ...



- Discussion to understand and clarify goals, values and wishes and decide on treatment options
- Document Goals, values and treatment wishes into an advance directive.
- Communicate to others verbally or in medical record the most recent documentation and discussion.



ACP needs for chronic illness

HEART FAILURE

Health Professional Perspective

- Complications
- Disease Burden
- Options for treatment



Patient and family perspective

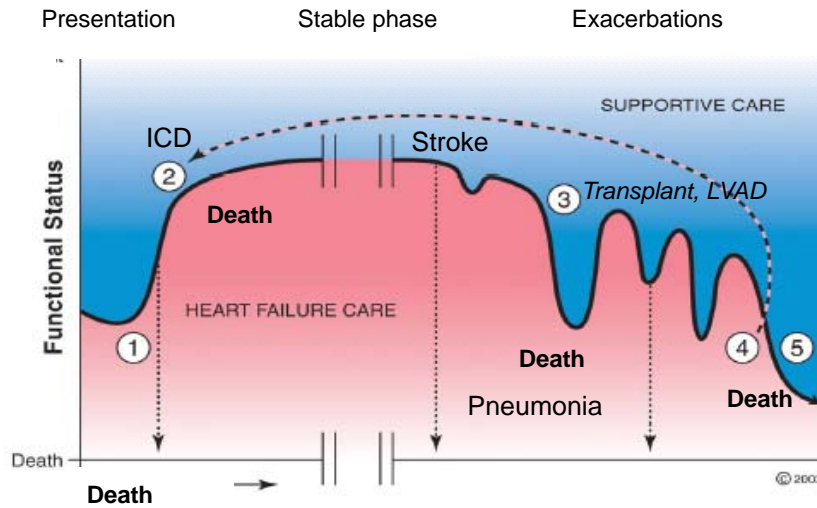
- Goals, Values, Religion, Culture
- Quality vs. length of life
- Treatment burden
- Treatment outcomes
- Likelihood of outcome

Informed
Consent



Shared
Decision
Making

The Trajectory of Heart Failure: When is Advance Care Planning appropriate?



Kuttner et al, Hospice Care for Patients with Heart Failure, AAHPM Annual Meeting, 2004.

ADVANCE CARE PLANNING

Planning for "bad" outcomes

What is the confidence level the care team, patient or family has had enough discussion and know the wishes about treatment options if there is a "Bad Outcome"?

Stroke --- tube feedings, nursing home

Pneumonia --- antibiotics, intubation

Arrhythmias --- ICD

Cardiomyopathy --- inotropic therapy, heart transplant

MI with heart failure --- CPR

Kidney insufficiency --- dialysis

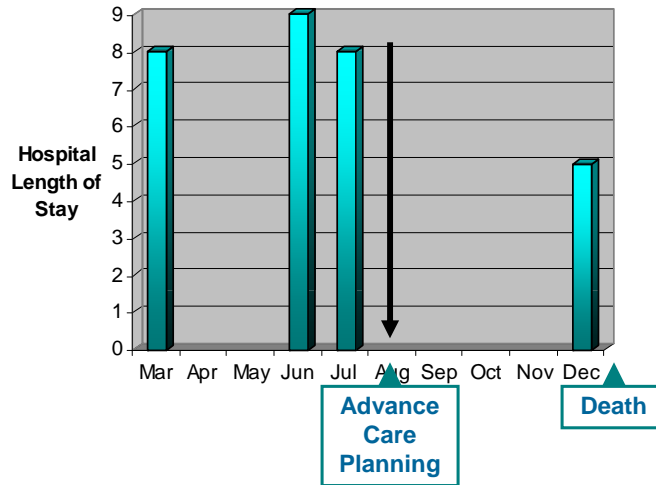
Complex/Disease Specific Advance Care Planning

- **Trusted Decision maker**
- **Common understanding of illness and complications**
- **Hopes and goals of care**
- **Concerns worries and fears**
- **Resources and support system when facing challenges**
- **Past and present experiences**
- **Quality of life --- low survival, physical or cognitive decline, specific treatment choices**

Health Professional Roles and Responsibility

- **Listen to the patient and family**
- **Talk to the right people ---**
 - **patient, family, friends, care team**
 - **Identify decision maker**
- **Review/Update current advance directives**
 - **Honor specific treatment wishes**
- **Encourage ongoing advance care planning**

A Case Study of Successful ACP
 Patient JM: Heart Failure, COPD, CRF, DM



What Did ACP Do for JM?

1. Defined his **quality of life**: "Get up each day and have breakfast."
2. Clarified **goals**:
 - No CPR
 - Avoid debility and burden to the family
 - Die in the hospital, not at home
3. Clarified **values**: his wife clearly understood what he meant by being 'debilitated.'



JM: Final Hospital Stay

- **He was admitted with pneumonia.**
- **He received IV antibiotics, but otherwise no aggressive interventions.**
- **JM died in the hospital, per his wishes.**

How Did ACP Help the Care Team?

- **The Cardiology nurse practitioner stated that she would not have known the specifics behind the patient's wishes, goals and values had it not been for the ACP session.**

“The information was invaluable in helping me honor his wishes at the end of his life.”

KL: Waiting for a heart transplant

- **64 year old married man**
- **Diagnosis: end-stage ischemic cardiomyopathy**

- **March: An ACP session was completed at home with the patient and his wife.**



KL: A donor heart becomes available



- **In June he receives a heart transplant**
- **He is re-intubated 8 days after surgery.**
- **Subsequent infections set in, with multi-system organ failure**
- **He dies 4 weeks after the transplant.**

KL's Advance Directive



On three occasions during the last few weeks of life his wife needed to make treatment decisions.

Each time she pulled out the Advance Care Planning documents and referenced the conversations she had had with her husband.



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Case Study

87 year old female admitted from nursing home without family present.



- Recurrent aspiration pneumonia and heart failure exacerbation.
- IV antibiotic therapy planned.
- 4 attempts to start IV access in the First 8 hours of hospital stay ---
- POLST Treatment preferences reviewed:
 - DNR
 - Limited interventions
 - No antibiotics or tube feedings.
- Care plan changed to oral antibiotic therapy.

Honoring treatment wishes

Practical Skills for ACP

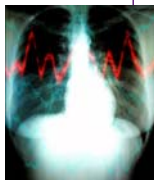


Your patient Susan is 68 years old, a mother of three, with new twin granddaughters. Susan has had hypertension for years, and seemed to be doing fine until 2 years ago when she came into the hospital very short of breath.

During the previous month she had begun to note swelling in her legs for the first time, and her energy seemed to flag.



Susan's story



- **There was no MI, but a work up showed the following:**
 - Normal systolic function with an EF of 55%
 - Moderately increased LV wall thickness
 - No evidence of coronary artery disease on a stress test
- ***What is her diagnosis?***



2 years go by



- **Initially, Susan’s symptoms responded to lisinopril and diuretics. She felt better, but then episodes of edema and shortness of breath began to recur.**
- **Now, Susan’s life is more restricted. She relies more on her husband to do the laundry, because it involves going up and down the basement stairs.**
- **She is a great patient, following her doctor’s orders and promptly going to the ED for symptoms.**
- **Susan completed a health care directive a year ago naming her husband & daughter as her health care agent --- no listing of specific wishes.**

What is on Susan’s mind??



- **She is readmitted with symptoms of HF. On day 2, you ask her how she is feeling, and how things are going at home.**

“I was doing just fine. A little tired maybe. We went to the cabin and I had a good time. But then the swelling started up again. Just a couple of days, and here I am!”

“Joe’s going to have to close up the cabin by himself this year. I wish I could help him.”

What is on Susan's mind??

"My daughter seems to be worried about me. Does she know something I don't? She keeps trying to get help for us at home, but I don't want strangers coming in.

"The cardiologist says I'm better today. She said my EF is normal, and the diuretics are doing their job.

"I just hope this improvement continues."



?What do you hear Susan saying about...

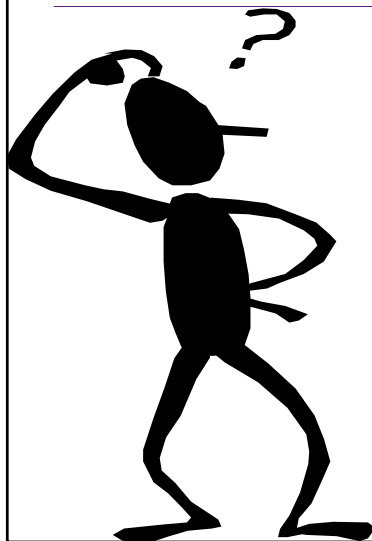
- **Function**
- **Disease status**
- **Support system**
- **Goals of care**
- **Prognosis**
- **Potential complications**



- **What are statements you have heard from patients that give you insight into:**
 - **their goals,**
 - **their understanding of prognosis, or**
 - **their worries about the future?**
- **What do you do next?**



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QUESTIONS?

eric.worden.anderson@allina.com
sandra.schellinger@allina.com