Getting the MOST from Advance Care Planning

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Objectives

- Discuss problems with advance directives (ADs)
- Describe the POLST/MOST initiative
- Discuss outcomes of POLST/MOST

What is Advance Care Planning?

- Making decisions about the care you would want for yourself at a time when incapacitated

Why care about Advance Care Planning?

- We're not getting any younger
- Don't want to end up like Shiavo
- New legislature

What is the Problem?

- Patient wishes for life-sustaining treatments are not consistently honored despite the availability of ADs
- Wishes ≠ Care Received

The Problem is…

- Communication
  - >70% of seriously ill patients have not discussed AD with their physician
  - <50% physicians knew when patients preferred DNAR status

Annals IM 1997

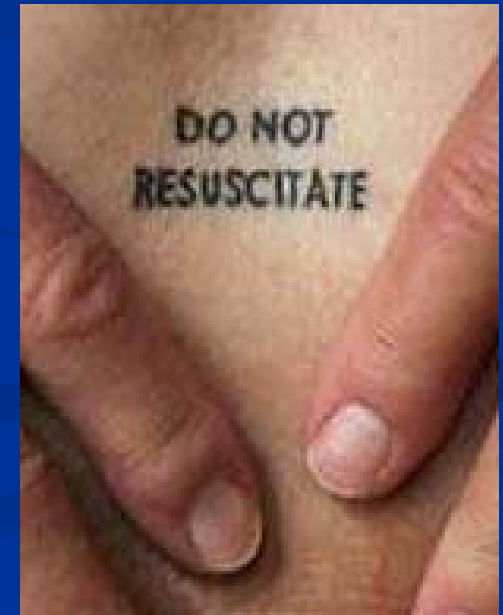
The Problem is…

- Communication (major cancer center)
  - Median time between DNAR order and death
    - Zero days
  - 5.5% inpatient deaths had previously signed DNAR order

Palliat Support Care 2008

How good are we?

- Disconnect = "not so good"
  - 22% had AD in chart
  - No significant association with AD in chart and DNAR order during terminal admission



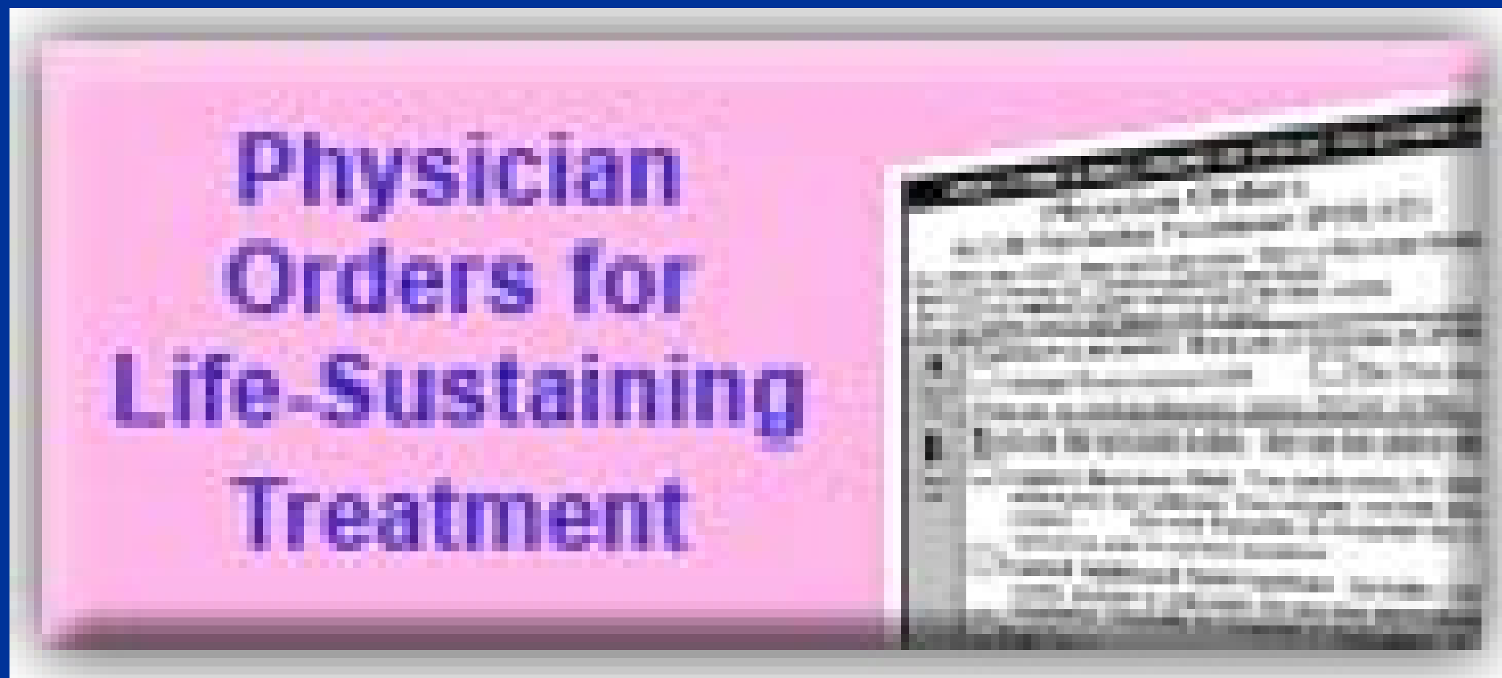
J Med Ethics 2008

How good are we?

- At UCH:
  - 25% charts document AD discussions

Change: POLST Paradigm

- **P**hysician **O**rders for **L**ife-**S**ustaining **T**reatment

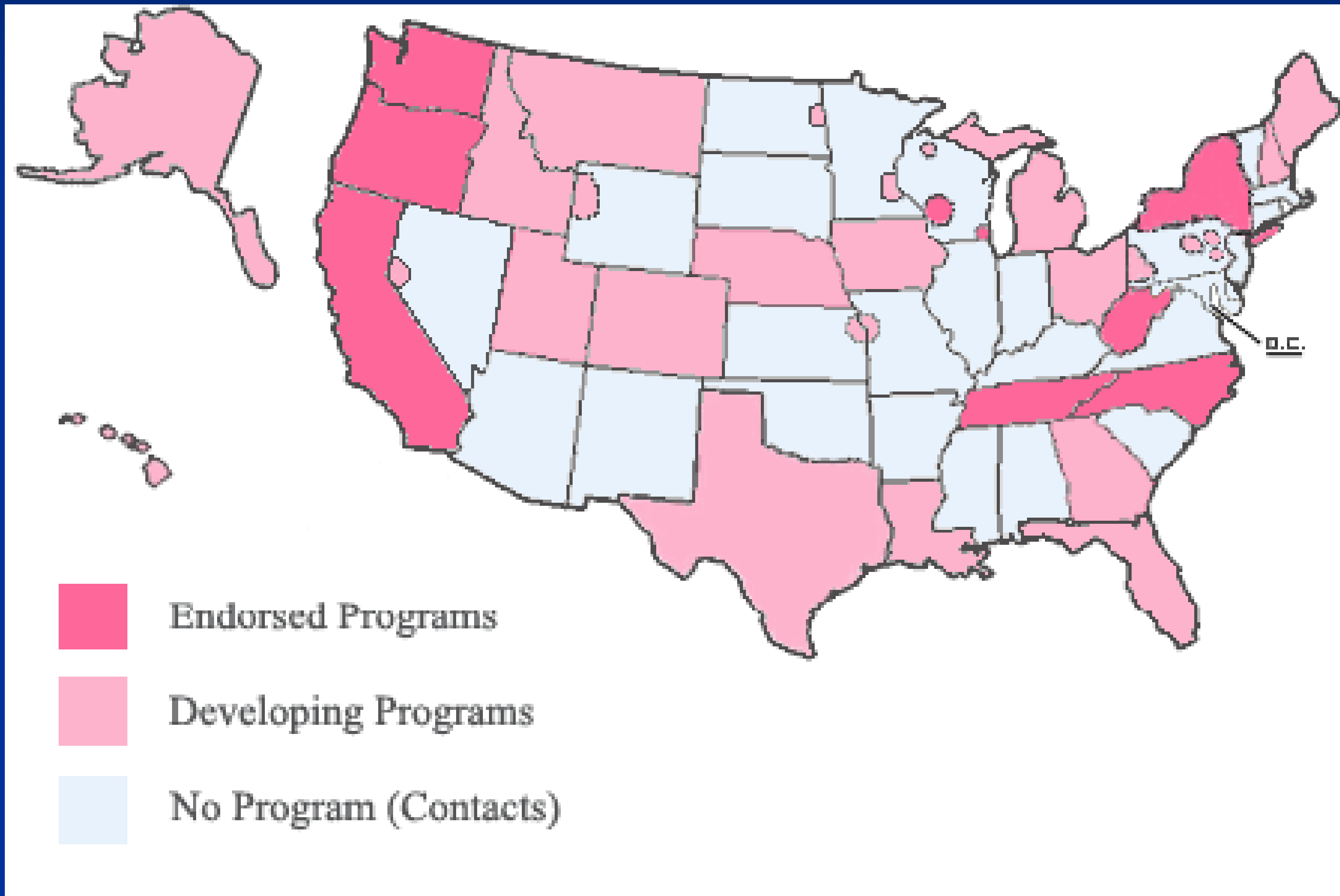


www.polst.org

POLST Paradigm

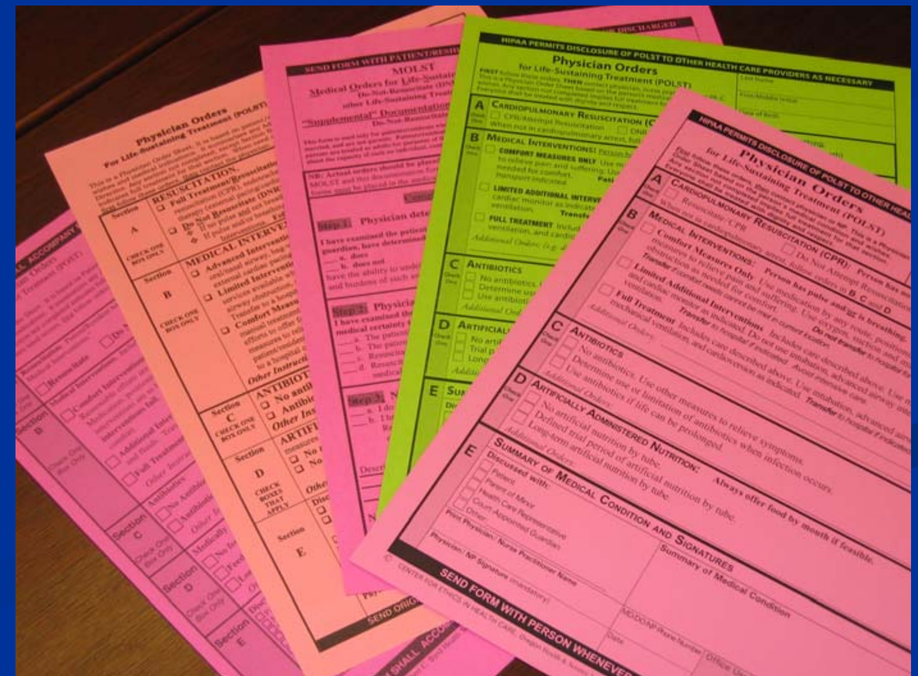
- Designed to improve end-of-life care
- Developed in Oregon in 1991
- Supported by the National Quality Forum as a Palliative Care "preferred practice"

POLST Programs



POLST → MOST

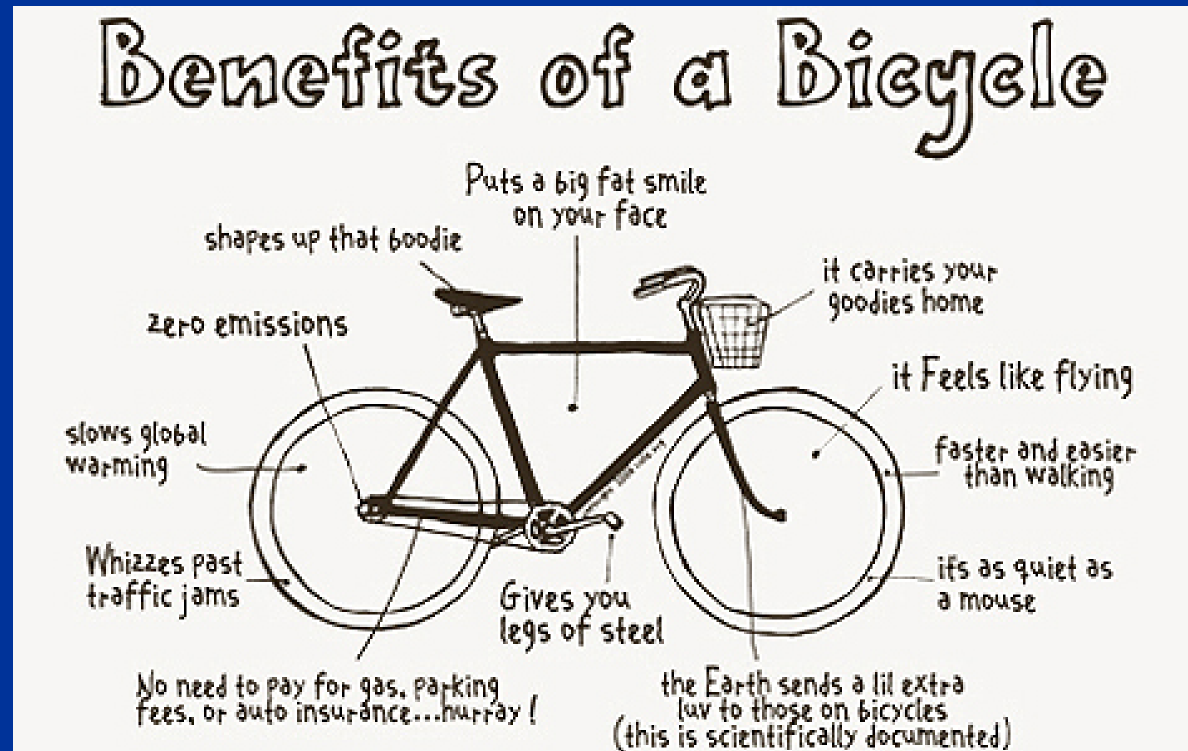
- Colorado version
- MOST
  - Medical Orders for Scope of Treatment



www.coloradoadvancedirectives.com

MOST: Benefits?

- Standardized
- Portable
- Updatable
- Effective



MOST: Standardized

- 1 page document
- Translates patient preferences for life-sustaining therapies into medical orders

MOST: Orders

- Set of orders
- **NOT** an advance directive (AD)
- Does **NOT** replace discussions of goals

MOST: Population

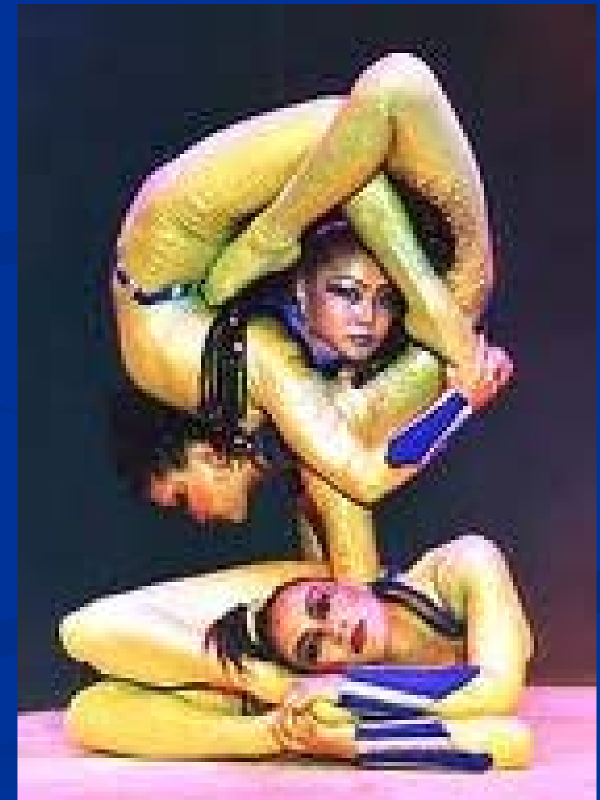
- Intended for use in:
  - Chronically or seriously ill
  - Medically frail
  - Nursing home residents
  - Anticipated life expectancy of 1-2 years

MOST: Flexible

- Signed by patient/surrogate
- Signed by physician, APN, PA
  - Verbal orders accepted
    - Co-sign within 30 days

MOST: Flexible

- Photocopies, faxes, electronic scans are valid



MOST: Clarity

- Pre-hospital
  - EMS rigidity
- In-hospital/facility
  - Flexibility
  - Medical appropriateness

MOST: Portable

- Transitions- honored in ANY setting
  - e.g., NH, LTCF, hospital, hospice, home
- Send original with patient when discharged to next setting

MOST: Updatable

- Prompts regular review and update

Advance Directives (ADs) vs MOST

	ADs	MOST
Who?	Every adult	Seriously ill
When?	Lack capacity	Not conditional on capacity
Decisions?	Myriad of future treatments	Relative to current condition
Preferences?	Need to be defined/interpreted	Presented as options
End-of-life care?	Patient preferences	Medical orders
Where?	Needs to be retrieved	Follows patient

MOST: Limitations

- Is this the answer to our problems?
  - Maybe a step in the right direction

Case 1

- 75 y/o resides in a NH
- Hx CAD, HTN, severe dementia
- Developed severe aspiration pneumonia
- MOST form:
  - Comfort measures only
  - Do not transfer to hospital for life-sustaining treatment
  - No antibiotics

MOST: Effective

- Improves incidence of advance care planning
- Improves adherence to expressed wishes

JAGS 1998; JAGS 2000; JAGS 2004; J Geront Nurs 2004; JAGS 2010; www.cchpc.org

Effective: EMT

- 45% changed standard treatment plan
- 93% useful in guiding decisions for patients in cardiopulmonary arrest

JAGS 2004

Effective: NH

- DNAR orders present on 88% POLST forms
- Zero with DNAR POLST orders received CPR/ICU care/vent support during terminal admission
- 13.7% with comfort measures only orders received life sustaining therapies

JAGS 2004; JAGS 1998; JAGS 2010

Effective: Translating Wishes

- 91% with DNAR POLST orders did not receive CPR
- 90% POLST accurately reflected wishes
- 90% wishes honored

JAGS 2000; J Geron Nurs 2004

MOST: Pearls

- Current AD not very effective
- **MOST**
  - Translates preferences into medical orders
  - Improves likelihood that EOL wishes are honored

RWHC Eye On Health
"My advance directive was for you not to show up."

MOST: Case

- 85 y/o F
  - Severe dementia
  - Peripheral vascular disease
  - Anti-phospholipid antibody syndrome
    - LE amputation
- Completed a medical living will 11 years ago before chronically ill
- Designated an MDPOA

MOST: Case

- AD states
  - When unconscious/comatose/otherwise incompetent for 7 days
  - Then withdraw/withhold life sustaining procedures
  - EXCEPT artificial nourishment shall be continued for 15 days if it's the only procedure being provided

MOST: Case

- Current state:
  - Incapacitated to make medical decisions
  - Severe dementia
  - Frequently doesn't recognize family
  - Unable to do ADLs
  - Unlikely to live past 1-2 years

MOST: Case

- MDPOA believes patient wouldn’t want artificial nourishment in current condition
- Based on previous conversations prior to severe dementia
- Never updated living will

MOST: Case

- Patient and MDPOA see PCP to complete MOST form
- Which box would you check regarding

  "D: Artificially Administered Nutrition and Hydration"?