FR14- Advanced Care Planning: Using the PACE (Program of All Inclusive Care for the Elderly Model Practice)

Friday, March 23
1:30 PM- 3:00 PM

Session Description

This session will demonstrate the benefits of integrating the National PACE Association (NPA) model practices in discussion of goals of care in LTC facilities. The three presenters will discuss how the NPA model practice was developed and the synergies that these model practices bring to LTC facilities. The presenters will also detail the “nuts and bolts” in implementing these goals of care discussion including approaches to staffing, training, care coordination, as well as with challenges and opportunities. This session will provide an opportunity for attendees to explore with presenters the details of the program and identify elements applicable to their own programs.

Learning Objectives

Describe a process to identify goals of care utilizing the National PACE Association Model Practice and how they may be utilized for advanced care planning.

Explain how integrating goals of care discussion increases the quality of care of all residents in nursing home.

Describe the fundamentals of shared decision making in the application of person-centered care.

Utilize effective communication with patients, staff, families and caregivers.

Presenter(s): Verna Sellers, MD, MPH, CMD; Luz Ramos-Bonner, MD, MBA, CMD; Renee Connolly, DNP, APRN

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
Advanced Care Planning: Using the PACE (Program of All Inclusive Care for the Elderly Model Practice)

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Speaker Disclosures
Drs. Ramos-Bonner, Sellers and Connolly have disclosed that they have no relevant financial relationships.

Learning Objectives
By the end of the session, participants will be able to:

- Describe a process to identify goals of care utilizing the National PACE Association Model Practice and how they may be utilize for advanced care planning
- Explain how integrating goals of care discussion increases the quality of care of all residents in nursing home
- Describe the fundamentals of shared decision making in the application of person-centered care
- Utilize effective communication with patients, staff, families and caregivers

NPA Model Practices: Adapting Clinical Practice Guidelines to the Older Adult in a Capitated Environment

VERNA SELLERS MD, MPH, AGSF, CMD, CHCQM
MEDICAL DIRECTOR CENTRA PACE AND GERIATRIC SERVICES LYNCHBURG, VIRGINIA

Sample patient scenario

- 85 yo male pt with OA; Diastolic HF w class 3 symptoms; DM complicated by neuropathy; CKD 3; AFib who needs assistance with bathing, dressing, and ambulation due to pain, DOE, and impaired balance
- What is the patient's current health status?
- What is the patient's blood pressure goal?
- Is colonoscopy screening needed?
- NSAID use?
- ACEI?
- Do you do interventions so that you can qualify for Pay for Performance or NCQA Physician recognition?

Objectives
- Describe the concept of Disease Management and the use of Clinical Practice Guidelines (CPGs)
- Understand some benefits and limitations of using CPGs in the geriatric population
- Describe a method of setting patient centered goals of care
- Demonstrate the use of the NPA Model Practices in advance care planning
Disease Management Definition

The concept of reducing healthcare costs and/or improving the quality of life for individuals with chronic disease conditions by preventing or minimizing the effects of a disease, usually a chronic disease, through integrative care.

Wikipedia.com (June 27, 2008)

Disease Management Tools

- Clinical Practice Guidelines (CPGs)
- Chronic Disease Management Programs
- Data Measurement
  - Hospitalization Rate
  - Re-Admission Rates
  - Testing Rates
  - Intervention Rates
- Care Managers
  - CHF nurse, DM educator
- Other staff: Nurse, Nutrition, SW
- The PACE iDT

Clinical Practice Guideline

- Systematically Developed Statements
- Evidence Based or Consensus Based
- Aim to
  - Improve the Quality of Care
  - Improve the Consistency of Care
- Typically developed by Expert panels who distill extensive data and opinion into a brief and understandable opinion
- Typically Addresses a single disease process in a specified population
- Examples: Dementia (Alzheimer’s Disease) Guideline, CHF, DM, HTN

Benefit of Guidelines

- Standardizes Care
- Sets out a default strategy for care
- Serves to educate the Provider
- Might be useful then in Quality measures
- Considered for use in Pay-for-Performance

Limitations of Guidelines

- Developed for management of a Single Disease
- Co-Morbid Conditions are often present
- Little evidence on applicability to older persons with multiple diseases

CPG and Quality of Care in Older Patients with Multiple Co-morbid Diseases

- Presents a 79 y.o. woman with 5 chronic conditions of moderate severity:
  - COPD (FEV1 = 1.2)
  - Hypertension
  - Diabetes
  - Osteoarthritis of knee and back
  - Osteoporosis
Case Report-Boyd 2
- SH: former smoker, lives alone, active socially, limited to walking 1 block
- Assumptions:
  - Followed explicit instructions when available
  - Assumed once per day dosing when available
  - Assumed Generic Drugs when available
  - Took advantage of potential synergies between CPGs
  - Chose medicines with least adverse effects/interactions

Case Report-Boyd 3
- Medications
  - 12 Medicines needed to comply with guidelines
  - 19 doses per day with 5 administration times
  - Cost of Meds: 407 per month
  - 14 non-pharmacologic activities such as daily foot checks, exercise, nutrition interventions, sugar monitoring

Case Report-Boyd 4
- Minimum of 4 primary care visits and one ophthalmology visit per year for chronic care including education
- Potential Treatment Interactions
  - Diuretics increase serum glucose and lipids
  - HCTZ may decrease effectiveness of glyburide
  - NSAIDs plus aspirin increase risk of bleeding and decrease effectiveness of aspirin in preventing cardiac events
  - NSAIDs raise blood pressure
  - Calcium supplements may decrease efficacy of aspirin
  - Aspirin plus alendronate can increase risk of GI complications

Case Report-Boyd 5
- Potential recommendation contradictions
  - Osteoporosis CPG advises weight bearing exercise
  - Diabetes CPG states to avoid weight bearing exercise if Peripheral neuropathy is present

Quality Assessment
- Easy to measure and thus give a score
  - HgA1c
  - Influenza vaccine
  - Eye exams in diabetics
  - Use of ACEI or ARB in CHF or CKD
  - Echocardiogram use in CHF
  - Mammograms and Colonoscopies
- NCQA (National Committee for Quality Assurance)
  - HEDIS measures (Healthcare Effectiveness Data and Information Set)
  - Voluntary Physician Recognition
- Pay-for-Performance

Study by Louise Walters
- Pitfalls of Converting Practice Guidelines into Quality Measures: Lessons learned from a VA Performance Measure
  - JAMA. 2004;291: 2466-2470
  - Walter, Davidowitz, Heinecken, Covinsky
Study – Walters 2

- Colorectal screening at the San Francisco VA Medical Center
- Screening Rate in 2002 was 58%
- Target was 65%
- Planned to put in place performance measures to meet the practice guideline
- Practice guidelines advise a course of action while performance measures are used to achieve standards

Study – Walters 3

- Pitfalls identified:
  - Not properly considering illness severity of the sample population
  - Not distinguishing screening from diagnostic procedures when setting target screening rates
  - Not accounting for patient preferences
  - Not accounting for clinician judgment
  - For many persons with severe co-morbid conditions, the risks of screening outweigh the benefits
  - Didn’t allow for removal of persons refusing or not appropriate from the denominator
  - Quality Care could mean not doing a colonoscopy if the risk exceeded the benefit

Counting Things

Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted.

Albert Einstein

Whoever undertakes to set himself up as a judge of Truth and Knowledge is shipwrecked by the laughter of the gods

Program of All Inclusive Care for the Elderly

Community based system of health care that delivers all needed medical and supportive services spanning the entire continuum of care for seniors with chronic care needs.

Designed to allow frail seniors to remain at home and in their communities providing an alternative to nursing home care.

Learning lab for best practices in geriatric medicine

PACE History

- 1971 Chinatown-North Beach in San Francisco sought long term care options. Together community leaders & Marie - Louise Ansak developed comprehensive, community based system of care.
- 1973 On Lok opened first day care center in San Francisco
- 1983 On Lok tested new financing system of PMPM
- 1986 Federal legislation allows for 10 additional organizations to replicate model

History

- 1990 PACE sites receive Medicaid/Medicare waivers
- 1994 National PACE Association (NPA) is formed with 11 PACE organizations in 9 states
- 1997 Balanced Budget Act establishes PACE as permanent provider
PACE by the numbers

- 31 states have PACE organizations
- 123 Sponsoring organizations
- 250 centers
- Enrollment from 2011- 2018 (<20,000 to >45,000)
- 30 day all cause Hospital readmission 19.1% (vs 22.9%)

As of 2/1/2018

PACE Criteria for Enrollment

- 55 years of age or older
- Meet state nursing home level of care criteria
- Reside in the PACE service area
- Be able to live safely in the community with the support of PACE


- Mean Age: 76 (80)
- 70% (75%) Women
- Average # Basic ADL Deficits: 3.5
- 46% dementia (63% Cognitive Impairment)
- Average Life Expectancy: 4.5 years
  - Heterogeneous
  - Different Goals

National PACE Association Mission

- Develop and promote the model of care
- Share best practices
- Work with CMS on regulatory issues
- Multidisciplinary and Interdisciplinary Groups within NPA
- Clinical arm is the Primary Care Committee: a clinician from each PACE Organization with
  - Medical Director, Program and Clinical Practices Subcommittees

NPA PCC Clinical Practice Subcommittee

- Coordinated approach to the use of CPGs
- Consistent Approach to the use of Quality Measures in our populations
- Collaborative discussions about interventions that are considered for our Enrollees
- Reports to the larger Primary Care Committee
Admission to PACE*
- Dept Social Service (SW) & Dept of Health (Nurse) home assessment & screening*
- PACE team home assessment, data collection
- PACE physician, nurse, therapist (PT, OT, RT) pharmacist assessments
- Advance care planning: participant's preferences and goals of care
- IDT Care plan development

Capitated Environment
- PACE Programs have:
  - Dual Eligible
    - Qualify for BOTH Medicare and Medicaid.
  - Medicare Only
    - Pay the Medicaid and Part D portions privately
    - Typically are on a spend down until they qualify for Medicaid.
  - Medicaid Only
    - Do not receive Medicare benefits.

Care Plan Development
- Participant preference
- Expectation
- Reality
  - Life expectancy
  - Benefit vs burden of intervention
- SMART (Specific, Measurable, Achievable/Agreed to, Realistic, Time-bound)

Set Overall Goal of Care
- Longevity
- Functional
- Comfort
- Hospice/EOL

Goal: Longevity
- Desires to live as long as possible
- Typically wants all medically indicated treatments
- Willing to comply with diet and activity recommendations and restrictions
- Willing to comply with medications and monitoring
- Usually accepts all surgeries, ICU admissions, Ventilator support, Dialysis, CPR and ACLS, IV therapies, Tube feeding and hydration

Goal: Functional
- Interested in preserving function
- Will pick and choose among invasive and noninvasive interventions
- Typically restricts some procedures such as CPR, dialysis, mechanical ventilation
- Typically wishes to limit some indicated medications
- Adapts to changing conditions
Goal: Comfort

- Comfort is the main concern
- Treatment choices are chosen by whether they contribute to comfort
- Life sustaining treatments are usually not desired: CPR, Mechanical ventilation, dialysis
- Few lab tests accepted
- Medications are only accepted that provide comfort or improve quality of life


Life Expectancy

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<th>Women</th>
<th>Men</th>
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<tbody>
<tr>
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<td>Age 70: 75th quartile: 18</td>
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<td>75th quartile: 13</td>
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<tr>
<td></td>
<td>25th quartile: 1.8</td>
<td>Age 90: 25th quartile: 1.5</td>
</tr>
</tbody>
</table>

Conditions contributing to or serving as a marker of increased mortality

- COPD*
- DM*
- Smoking
- Alcoholism
- Physical Inactivity
- Obesity
- Depression
- CHF* Class 3 or 4
- Previous Stroke
- Dementia*
- Functionally impaired
- Previous MI
- PVD
- CKD*
- Cancer
- Parkinson’s Disease
- Falls
- Antipsychotic Use in pts with Dementia

*NPA model practice

Prediction of Mortality in PACE participants

Carey, Elise; Covinsky, Ken; Walter, Louise; Eng, Catherine; et al. JAGS 56:68-75 2008

- POINTS ASSIGNED:
  - Male Sex (2 pts)
  - Age over 75 (2 pts, >85 3 pts)
  - Dependence in toileting (1 pt)
  - Dependence in dressing (1pt if partial or 3 pts if complete)
  - Malignant neoplasm (2 pts)
  - Congestive Heart Failure (3 pts)
  - COPD (1 pt)
  - Renal Insufficiency or Failure (CKD) (3 pts)

- If over 5 pts, then:
  - 1 yr mortality = 21%
  - 3 yr mortality >=54%

Preventive Care Guideline methodology

- 2006 Version
- Workgroup assembled: the Clinical Practice Subcommittee
- Updated recommendations and review sources: create database
- Added Pathways/broad goals
- Consensus recommendations by evidence if available or expertise/opinion

Organizations/CPGs Used as Standard

- ACIP
- ACS
- ACOVE
- ACOG
- ACP
- AGA
- AGS
- AMDA
- AUA
- CTFPHC
- USPSTF
Layout of Form

- Intervention
- 3 Pathways
- Interval
- By Whom
- Categories:
  - General
  - Immunizations
  - Disease or Injury Prevention
  - Examinations
  - Cancer Screenings
  - Testing

Definitions

- Yes: do the intervention
- No: do not do it
- Consider: Do the test or intervention if you will act on the result
- Initially: the first 6 months of enrollment in PACE
- Nursing: RN or under the direction of an RN (PACE regulation for RN assessments)
- PACE regulations: Federal register: title 42, Chapter IV, Subchapter E
- PCP: Primary Care Provider: physician, NP, PA (current PACE regulation is for the physician to be the PCP)
- Screening: Look for disease or findings that are not known previously to be present
- LE: Life Expectancy
Summary

- CPGs help define standard practice for an individual disease or condition
- We treat patients and not diseases
- Interventions have benefits and risks and that balance changes with LE and co-morbid conditions
- CPGs are being used as a basis for measuring quality and Pay-for-Performance
- NPA Model Practices provide relevant management recommendations. They are not intended to replace clinical judgement of the provider or establish a standard of care.
What is your criteria for a Good Death?

- Studies have shown that approximately 80% of Americans would prefer to die at home, if possible.
- 60% of Americans die in acute care hospitals.
- 20% in nursing homes.
- 20% at home.
- A minority of dying patients use hospice care and even those patients are often referred to hospice only in the last 3-4 weeks of life.
Core Themes and Subthemes of a Good Death and/or Successful Dying

<table>
<thead>
<tr>
<th>Core Theme</th>
<th>Subtheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life completion</td>
<td>Saying goodbye, life well lived, acceptance of death</td>
</tr>
<tr>
<td>Religious/spiritual</td>
<td>Religious/spiritual comfort, faith, spirit with clergy</td>
</tr>
<tr>
<td>Treatment preferences</td>
<td>Not prolonging life, belief that all available treatments were used, control over treatment, euthanasia/physician assisted suicide</td>
</tr>
<tr>
<td>Quality of life</td>
<td>Living as usual, maintaining hope, pleasure and gratitude, life is worth living</td>
</tr>
</tbody>
</table>

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<tr>
<td>Relationship with HCP</td>
<td>Trust/support/comfort from physician/nurse, physician is comfortable with death/dying, discuss spiritual beliefs/fears with physician</td>
</tr>
<tr>
<td>Other</td>
<td>Recognition of culture, physical touch, being with pets, healthcare costs</td>
</tr>
</tbody>
</table>

Being Mortal

“...our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one’s story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone’s lives.”

Why is the discussion important?

- Good communication – cornerstone of high-quality medical care
- Better patient outcomes, improved patient and family satisfaction with care
- Reductions in hospital utilization and aggressiveness at end of life, increase use of hospice services, decreased family conflict, and a greater likelihood of dying in one’s preferred place of death


“Eliciting Goals of Care in the Nursing Home”

BARRIERS
- Fear of legal ramifications
- Not enough education in goals of care discussion
- Family not involved in a regular basis
- Time pressure
- IDT not involved

ENABLERS
- Education/experience to goals of care discussion
- IDT involvement
- Established trusting relationship with patient/family/other staff
- Terminal diagnosis/hospice involvement
- Discussion occurs in person

Types of Advance Directives

- Health Care Proxy
- Durable Power of Attorney for Health Care, Medical Power of Attorney
- Living Will
- Physician’s Order for Life-Sustaining Treatment (POLST) – medical orders

*May vary from state to state.
Factors Influencing Communication

- Open-ended questions,
- Reflective statements,
- Intuitive knowledge,
- Empathic statements

Factors Influencing Communication

- Deep listening
- Recognize emotions
- Practitioner Self Assessment of own Bias and Fears

Communication Skills

- Can be learned
- Do not automatically improve with time, if no effort
- Needs active reflection, feedback and practice
- Interactive workshops more likely to result in practice change. Didactics alone are not effective.

(Thomson, Freemantle, et al. Cochrane Database of Systematic Reviews 2005)
### Strategies to Improve Skills

- Know your personal strengths and weaknesses
- Use appropriate language
- Try to speak in English – not “medicalise”
- Appropriate use of
  - Silence
  - Empathic response
- Develop a script
- Develop confidence

### Sensitive Delivery of Difficult News

- ASK – TELL – ASK
  - Ask – What have you been told?
  - Tell – This is what is happening
  - Ask – What do you know now?

#### Sensitive Delivery of Difficult News

- Nurse
  - N – Naming
  - U – Understanding
  - R – Respecting
  - S – Supporting
  - E – Exploring

- "I wish…" “I’m worried…”
  - I wish… (this were different) (this wasn’t so) (this stroke never happened) (your mother would have a miracle recovery)
  - I’m worried… (about how to prepare for what may happen next) (that you and your family may not be prepared for the care giving now needed (because your kidneys are not working as well as they should)

### Identifying Goals of Care

- Necessary during transition of care or focus of care
- Ascertain all stakeholders (especially that ones that you would rather avoid!)
- Set framework via structured family meeting
- Assess & acknowledge understanding of current condition

### Family Meeting Elements

- Pre-meeting
- Introduction & agenda review
- Ask-tell-Ask
- Empathize
- Highlight participant’s voice & wishes in their vernacular
- Review the next steps together
Shared Decision Making

- **Shared decision making** is a key component of patient-centered health care. It is a process in which clinicians and patients work together to make decisions and select tests, treatments and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values.
  
  - [https://www.healthit.gov/sites/default/files/nlc_shared_decision_making_fact_sheet.pdf](https://www.healthit.gov/sites/default/files/nlc_shared_decision_making_fact_sheet.pdf)

**Shared Decision Making – 4-step Process**

1. Determine if decision is appropriate for SDM
2. Offer choice
3. Provide options
4. Elicit patient preference & decision

Family Meeting

- Reflect post meeting – what did we learn?
- What went well? Not so well?

Goals of care discussion

- Occur early in the disease trajectory
- Exploratory, conversational, and longitudinal
- Processing of complex information – best done outside of crisis situations
- Not limited to end of life care – part of every clinical encounter

Why is this discussion important?

- Help participants and their caregivers and families to come to terms with the realities of their prognosis and help facilitate alignment of participant and family values

Pitfalls

- Starting too late
- Expecting too much too soon
- Trying to deliver serious news in one sitting
- Biasing the conversation
TAKE HOME POINTS

• Use a systematic approach in discussing goals of care
• Goals of care discussion should occur early and often
• Effective communication with participants and families is therapeutic and often resolves conflict
• Practice, Practice, Practice

Nuts and Bolts

Germantown Home

• 180 bed post acute and LTC facility
• Two types of Residents
  • PACE residents
  • Non-PACE residents

NP Role

• Serve the Non-PACE population
• Opportunity to observe PACE model of care

Observation of the PACE Approach

• Resident/Family Content with process
• Team
  • Provide more support
• Satisfaction among IDT members

Why We Needed to Change
Dissatisfaction with Former Process

- Provider
  - Time Constraints
  - Cookie-Cutter Medicine

- Resident & Family
  - Feeling Rushed
  - “Taking up the Doctor’s Time”
  - Answers not fully understood
  - Questions, Questions, Questions!

Unanswered Questions = Unhappy Consumers

- Staff
  - Conflicted
    - Family members have different wishes for loved ones
    - Loved ones discuss with staff

Conflicted & Confused!

Need A Process

How could we create a positive death experience that addresses peace of mind for:
1. Family & Resident
2. Health Care Team

First Attempt

- 2017
- On Admission: Social worker/PCP discuss POLST
- PCP Follow Up
  - 16% completed at Germantown Home

How Do You Define Success?

- By getting a “D” for DNR- is that a win? A Success?
- Current process/system not completely successful with family and staff
PACE Program for Dying

- The Process:
  - Discussion, Discussion, Discussion
  - Team involvement
- Purpose:
  - buy in
  - understand family wishes/value
  - decrease emotional conflict
  - “everybody on the same page”

How To Get There

Education

- Staff
- Residents
- Family
- PCPS

Staff Education

- NHA Down The Line
  1. Explanation of “more meetings”
  2. Familiarity with “new terms”
  3. THE CHOICES/ Goals of Care
     Longevity vs. Function vs. Palliation

Resident & Family Education

- IDT meets with resident and important people in resident’s life
  - Permission who attends
    - Resident
    - If resident cannot decide, turn to resident representative

Points to Consider

- Slow and Steady
- Non-Medical Terminology
- Know your audience
  - Cultural differences
  - Important People

Remember the Tissues!

Cultural Differences

- African Americans
  - Kaiser Health News Recent Poll
    - 19% of AA documented end of life wishes
    - AA more likely than white patients to prioritize living “as long as possible”
    - Why?
      - Historical mistrust of medical establishment
End of Life Discussions

- Earlier better than later
- Be sensitive to resident & family’s ability to process information and emotional needs
- Should Include
  - Trajectory of medical condition
  - What EOL will look like
  - Options
- Never forget the **finality** of death

Trust the Process

- Initially 16% of population with completed Advanced Directives
- March 2018
  - 97% of residents with code status orders

Case Studies

Questions?

The End