

# KHC Office Hours

## Advanced Directives are for the Living - Improving Workflows in Your Organization

Ryan Pferdehirt, Vice President of Ethics Services  
Practical Bioethics



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## Today's Webinar Agenda

- Welcome – 5 mins
- Content Presentation 45 mins
- Q&A 5 Mins
- Closing Comments 2 mins

# AGENDA



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***Register Today!***

**KHC Summit on Quality  
August 8<sup>th</sup>, 2024  
Wichita, KS  
Wichita State University  
Rhatigan Student Center**

[Learn More](#)



  
Kansas Healthcare  
COLLABORATIVE

## Summit on Quality

August 8, 2024

**Wichita State University  
Rhatigan Student Center**

**Audience**  
Clinicians, Nurse Leaders, Hospital and Clinic Leaders,  
Infection Preventionists, Pharmacists and Quality Leaders

**[Register Here](#)**

Registration Cost \$150: Includes lunch and CNE\*

The Summit on Quality is an educational event drawing health care leaders from across Kansas. Now in its 15th year, Summit programming is designed to engage and connect a wide range of health care professionals—including physicians (particularly residents), nurses, clinic managers, hospital CEOs and other senior management, quality improvement professionals, risk managers, infection preventionists, long-term care providers and other interested health care professionals—practicing in both urban and rural settings throughout our state.

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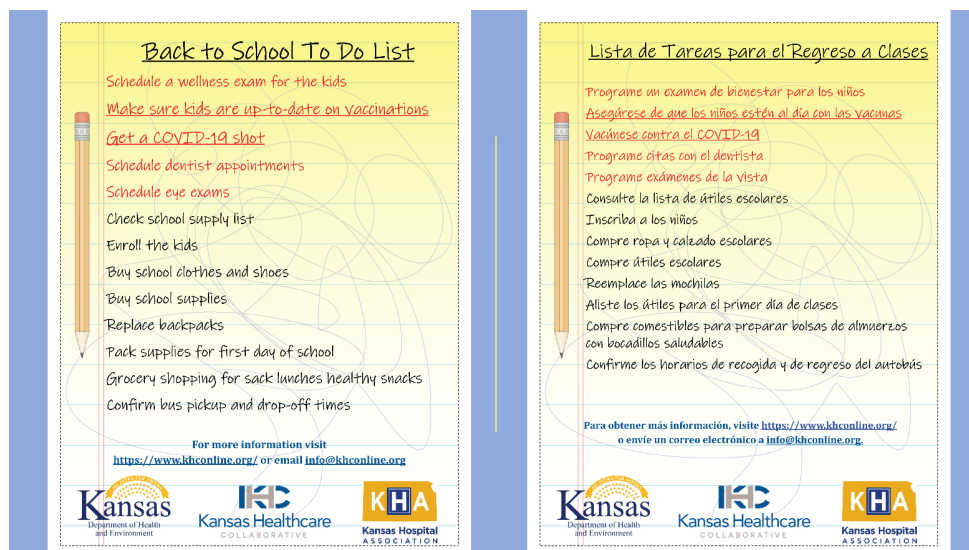
## KHC Building Vaccine Confidence Resources Page

- <https://www.khconline.org/initiatives/provider-led-initiatives/building-vaccine-confidence>
- Downloadable KHC Posters
- Content from KDHE, Immunize Kansas Coalition and the CDC
  - Vaccine Resources
  - Toolkits
  - Storage and Handling Info



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## Back to School Posters



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## Ready for Fall Posters

**Are you ready for fall?**

**To Do List**

- Service the furnace
- Replace furnace filter
- Cover AC unit
- Clean the chimney
- Clean the gutters
- Rake the leaves
- Check antifreeze in car
- Change wiper blades
- Plant mums
- Fertilize lawn
- Pack away summer clothes
- Schedule Wellness Exam
- Schedule Eye Exam
- Schedule Mammogram
- ✓ Get Flu Shot
- ✓ Get COVID-19 vaccine

For more information visit <https://www.khconline.org/> or email [info@khconline.org](mailto:info@khconline.org)

**¿Está listo para el otoño?**

**Lista de Tareas**

- Dale mantenimiento al sistema de calefacción
- Reemplaza los filtros de la calefacción
- Cubre la unidad de aire acondicionado
- Limpia la chimenea
- Limpie las canaleras
- Barra las hojas
- Revise el anticongelante en el coche
- Cambie las escobillas limpiaparabrisas
- Plante crisantemos
- Fertilice el césped
- Guarde la ropa de verano
- Programe un examen de bienestar
- Programe un examen de la vista
- Programe una mamografía
- ✓ Vacíense contra la gripe
- ✓ Vacíense contra el COVID-19

Para obtener más información, visite <https://www.khconline.org/> o envíe un correo electrónico a [info@khconline.org](mailto:info@khconline.org)

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## Before You Travel Posters

Before you hit the road to visit family for the holidays...

- ✓ Get Flu Shot\*
- ✓ Get COVID Vaccine\*
- Adjust the thermostat
- Confirm the pet sitter
- Set timer for lights
- Call neighbor to get the mail
- Lock all doors and windows
- Pack snacks and games
- Check all appliances
- Load Luggage in the car

\*If you're eligible, visit <https://www.khconline.org/> or call [1-800-442-2222](https://www.khconline.org/1-800-442-2222) for more information.

Antes de salir de viaje a visitar a su familia para las fiestas...

- ✓ Vacíense contra la gripe\*
- ✓ Vacíense contra el COVID\*
- Ajuste la temperatura del termostato
- Confirme que su mascota tendrá quien la cuido
- Programe el temporizador de luces
- Llame a su vecino para que le recoja la correspondencia
- Cierre todas las puertas y ventanas con llave
- Prepare refrigerios y juegos para llevar en el viaje
- Controle el estado de todos los electrodomésticos
- Cargue el equipaje en el vehículo

\*Si es elegible para vacunarse, visite <https://www.khconline.org/> o llame al [1-800-442-2222](https://www.khconline.org/1-800-442-2222) para obtener más información.

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# Advanced Directives are for the Living - Improving Workflows in Your Organization

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26 JUNE 2024

RYAN PFERDEHIRT

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## Objectives

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- Explain the importance of Advance Directive, Advance Care Planning, etc.
- Give examples of the limitations of Advance Directives and how to overcome them
- Give strategies for implementation for ACP conversation and AD completion

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## Case Example

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Patient presents to the emergency department after being found down in apartment, then admitted to the ICU. Pt is a 92-year-old female, and is suffering from suspected cancer, in addition to end-stage dementia. The pt has failed multiple swallow evaluation. Pt is in a nonresponsive state and lacks capacity. There is no completed advance directive or DPOA paperwork, and the pt is unknown to the medical team (no EMR record). At this time, the pt does not have any family, acquaintances, or anyone close to him/her.

Medical decisions, including how aggressive care should be, need to be made. Particularly pressing is the question of placement of peg and trach.

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## Case Example

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80 yr male with multiple medical problems with esrd, dementia, stroke, bed ridden and with low blood pressure chronic. No responsive to medical team

Pt AD states, if only artificially prolonging life and no meaningful interactions with family...withhold treatments" from 2009.

- Medical team believes at this point, daughter (DPOA) disagrees

Daughter is primary care giver, quit work to care for father (pt), siblings in disagreement with daughter

2<sup>nd</sup> opinion of futile care had nephrologist disagree with approach but not futility of care.

Question: Do you do another round of dialysis?

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## Case Study

A 64-year-old woman with MS is hospitalized. The team feels she may need to be placed on a feeding tube soon to assure adequate nourishment. They ask the patient about this in the morning and she agrees. However, in the evening (before the tube has been placed), the patient becomes disoriented and seems confused about her decision to have the feeding tube placed. She tells the team she doesn't want it in. They revisit the question in the morning, when the patient is again lucid. Unable to recall her state of mind from the previous evening, the patient again agrees to the procedure.

UW Bioethics

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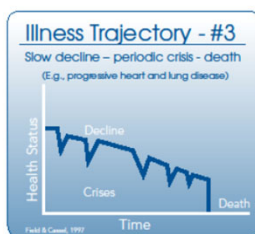
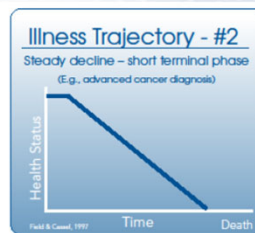
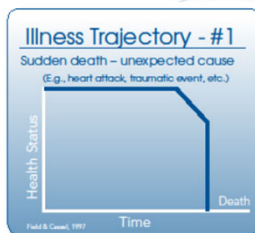
## ACP Conundrum

- People are reluctant to think or talk about serious illness, goals of care and death
- Especially when things are going well and people feel pretty good
- But this is exactly the time to have these conversations and make plans
- DO NOT wait until you are seriously ill
- Variety of tools to guide you through this process—including this talk and your wristband

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# Pictures of Illness

The four basic ways a person might experience an illness or serious health condition



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# Advance Directives



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## Clinical Decision Making

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1. The Patient with Capacity
2. Autonomously Executed Advance Directive
3. Substitutive Judgement
4. Best Interests

2 – 4 Require a Surrogate Decision-maker

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## The Patient with Capacity

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- Informed Consent
- First used, 1957 by attorney Paul G. Gebhard – malpractice case v Stanford
- Requires 3 element criteria
  - Patient must *agree* to intervention based on *understanding* of relevant *information*
  - Must *not be controlled* by influences
  - Must involved intentional giving of *permission*

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## Informed Consent

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- Required by patient;
  - Understand, Evaluate, & Reason
- Required by provider;
  - **Diagnosis, Prognosis, Treatment Options, & Recommendation**
- Ensures pts are aware = protects hospital and physicians from litigation
- Ethically – It should be minimum/baseline

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## Advance Directives and Surrogate Decision Makers

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- Precedent autonomy
- Means of maintaining a patient's right to autonomy
  - A patient's voice when the patient is voiceless
- Advance Directive
  - Living will, DPOA, 5 Wishes, etc.
  - Does not include POLST/TPOPP

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## Legality and Risks

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- The Patient Self-Determination Act – 1990
- At admission
  - Ask the patient if they have an advance directive, and document that fact in your medical record
  - Not required to make sure a copy is provided or completed
  - Provide info on patient's health care decision-making rights (Advance directive)
  - Provide info on policies with respect to recognizing advance directives

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## Challenges and Limitations

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- Living wills cannot cover all conceivable decisions
- Questionable pt understanding
- Ambiguous terms
  - "extraordinary means" and "unnaturally prolonging my life"
- Effective use
  - Advance Directives and POLST

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# Kansas AD

**DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS**

**DECISION TO NAME SOMEONE TO SPEAK FOR ME**

I, (your name) \_\_\_\_\_, (state of birth) \_\_\_\_\_, appoint the following person(s) to make healthcare decisions for me when I am unable to make or communicate my own wishes:  
 Agent may not be the treating healthcare provider, an employee of the treating healthcare provider, or an employee, owner, director or officer of a facility, unless that person is a relative or is bound to you by common vows to a religious life.

**PLEASE PRINT:**

Name of Agent: \_\_\_\_\_ Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Agent's address: \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
 Name of First Alternate Agent: \_\_\_\_\_ Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Agent's address: \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
 Name of Second Alternate Agent: \_\_\_\_\_ Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Agent's address: \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

This power of attorney for healthcare decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding healthcare. This power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.

**AUTHORITY GRANTED**

My healthcare agent may:

1. Consent, refuse consent or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition;
2. Make all arrangements for me at any hospital, treatment facility, hospice, nursing home or similar institution;
3. Employ or discharge healthcare personnel including physicians, psychiatrists, dentists, nurses, therapists or other persons who provide treatment for me;
4. Request, receive and review any information, spoken or written, regarding my personal affairs or physical or mental health including medical and hospital records, and execute any releases or other documents that may be required in order to obtain such information; and
5. Make decisions about organ and tissue donations, autopsy and the disposition of my body.

My agent shall authorize consent for the following special instructions:

I wish to be a donor for organs and tissues.  
 I have attached information about treatment choices I wish to have honored by my agent. \_\_\_\_\_ page(s) attached.

**LIMITATIONS ON AUTHORITY GRANTED**

My healthcare agent may not:

1. Exceed the powers set out in writing in this document; or
2. Revoke any existing Living Will Declaration I may have.

X \_\_\_\_\_ date \_\_\_\_\_  
 (Signature)

**Notary Public:** \_\_\_\_\_ Notary Seal: \_\_\_\_\_  
 STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_  
 This instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_ (month, year)  
 Signature of Notary \_\_\_\_\_

**OR**

Witnesses: (witnesses may not be the agent or a relative, or beneficiary of the principal)

X \_\_\_\_\_ Date: \_\_\_\_\_  
 (Signature)

X \_\_\_\_\_ Date: \_\_\_\_\_  
 (Signature)



This document is based on Kansas Statutes Annotated, §§ 465 through 652.  
 Additional forms and information are available through  
**Wichita Medical Research & Education Foundation**  
 300 E. Central, Wichita, KS 67208  
 316-686-7172  
[www.wichitamedicalexeducation.org](http://www.wichitamedicalexeducation.org)

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# Health Care



"The Doctor will see you now. Here's your medical jargon dictionary."

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## What if there is not an AD?

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## Substitutive Judgement

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- “Don the mental mantle of the incompetent”
- Surrogate should have familiarity with the patient
- Able to answer, “what would *the patient* want in this circumstance?”

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## Best Interests

### Best Interest Standard

- Determine the highest probable net benefit among the available options
- Balance benefits, risks, and cost

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## Best Interest Standard

**BENEFIT**

**RISK**



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## Who should a patient select?

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- Be at least 18 years or older
- **Not** be your health care provider, employee of health care facility
  - Unless he/she is your spouse partner, etc.
- Understand what a health care agent does and be willing to do this role
- Be able to talk on your behalf about your goals, values, and preferences, etc.
- Carry out your decisions (even if he or she does not agree with them).
- Be able to make decision in difficult or stressful times.

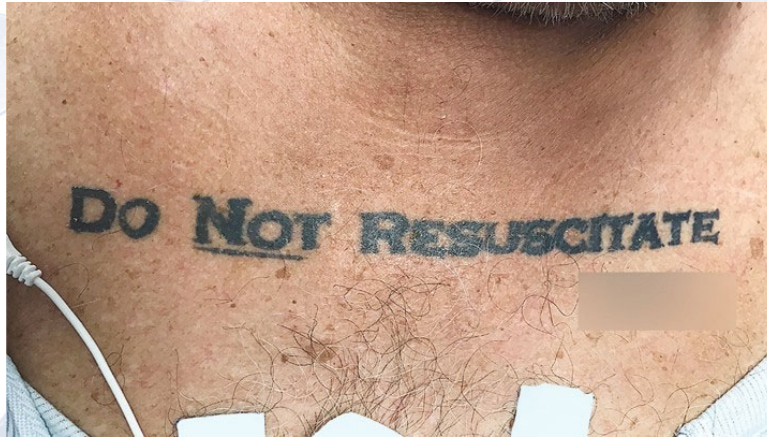
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## No DPOA - Who becomes Surrogates?

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- Appointed Guardian
- Husbands, wives, legal partners
- Adult children
- Parents
- Siblings, cousins, aunts, uncles, nephews, nieces
- Close and caring friends
- (defined by each state laws)

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## Conversations are Key

Earlier conversations about patient goals and priorities for living with serious illness are associated with:

- ✓ Enhanced goal-concordant care Mack JCO 2010
- ✓ Improved quality of life
- ✓ Reduced suffering
- ✓ Better patient and family coping
- ✓ Higher patient satisfaction Detering BMJ 2010
- ✓ Less non-beneficial care and costs Wright 2008, Zhang 2009

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## Too little, too late, not great

- Multiple studies show patients with serious medical illnesses do not discuss EOL preferences, or first discuss them only in the last days to month of life Wright 2008, Dow 2010, Halpern 2011
- Among patients with advanced cancer:
  - First EOL discussion occurred median 33 days before death Mack AIM 2012
  - 55% of initial EOL discussions occurred in the hospital
  - Only 25% of these discussions were conducted by the patient's oncologist Mack AIM 2012

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## Implementing AD

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## What does not work?

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- Expecting patient to complete them on their own
  - ~20%/30% completion rate
- Mailing advance direction
- Even general advance directive completion is not enough
  - The conversation is important

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## Workflow

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- When you engage with AD?
  - Implementing language in normal conversations
- Integration is best
  - Already existing workflows
- Strategies
  - Age 18
  - Wellness visits
- Pilot successes and lack of successes
  - Success – Employees
  - Less success- New Diabetes diagnosis clinic workshops

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## Starts with the Medical Team

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- Complete your own advance directive
- Be ready to answer any questions
- Have readily available

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## Final Takeaways

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- This is challenging and only going to get worse
- Open communication and shared decision making
  - Take the time to engage with patients
  - Ask open questions
- Balancing Paternalism and Pt Autonomy
- Do not redesign the wheel
  - Integration into already existing workflow

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## Questions and Contact Info

Ryan Pferdehirt, D.Bioethics, [HEC-C](#) |  
Center for Practical Bioethics  
Email: [Rpferdehirt@practicalbioethics.org](mailto:Rpferdehirt@practicalbioethics.org)  
Phone: 412.370.4629



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## Upcoming Education and Important Dates

- [7/9 KHA De-escalation Techniques Webinar](#)
- [7/11 Navigating Rural Health Resources - Statewide Farmwork Health Program](#)
- [7/24 KHC Office Hours - PFAC: Are Your Teams Engaged?](#)
- **[7/18 KHC Leadership in Quality Awards Due](#)**
- [7/31 Save the Date -MC KHA Healthy Equity Webinar - Transportation](#)
- [8/8 KHC Summit on Quality](#)
- [9/5-9/6 KHA Convention and Trade Show - Overland Park, KS](#)
- [10/30 Kansas Health Equity Summit](#)

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