

## FUTURE MEDICAL PLANNING IN DEMENTIA – PROMISES AND PITFALLS

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## Outline

- Approaches to medical care planning
- Identifying resources
- Discussing common challenges of being a decision maker



## Who are you? (Part One)

- Who here has a written Living Will or Medical Power of Attorney?
- How many of you have designated someone to speak for you - an "agent"?
- How many of you are the "agent" for someone else?
- How many of you have talked about what is important to YOU at the end of your life?

## Who are you? (Part Two)

- How many of you are living with cognitive issues?
- How many are living with a loved one with cognitive issues?

Briefly - What questions would you like to talk about today?

## WHAT IS ADVANCE CARE PLANNING?

What does it mean to you?  
Why does it matter?

## Advance Care Planning

Discussions with and Designation of Decision Makers

Discussions about Values & Preferences

Discussions about Specific Treatments

Documentation (clinician notes, directives)

## How does dying happen?

→ There are **3** main trajectories of physical decline in people with advanced illness:

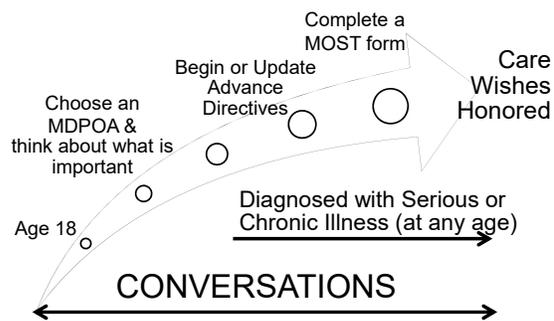
**RAPID decline**  
-typically cancer

**INTERMITTENT decline**  
-typically organ failure

**GRADUAL decline**  
-typically frailty or dementia

Murray SA - Illness trajectories and palliative care. BMJ 2005.

## Where does Advance Care Planning Fit?



### The Goal: To Honor Preferences

- Many (but not all) people are more concerned about quality than quantity.
- Many....want to die surrounded by loved ones, in a familiar situation.
- For some, meeting family needs may be what is most important to the individual.

IT IS ALWAYS TOO SOON TO START  
THE CONVERSATION...  
UNTIL IT IS TOO LATE

*Ellen Goodman*



### What is important to you?

#### Reflect on your values and personal beliefs:

- ❖ Family and upbringing experiences
- ❖ Spirituality and faith
- ❖ Life legacies
- ❖ Meaning
- ❖ Periods/experiences of growth

The Conversation Project

### Questions to consider for end of life care:

- ❖ What matters to me in life is \_\_\_\_\_.
- ❖ Would you prefer to spend your days and receive medical care?
- ❖ Are you worried about too little care or too much medical care?



the conversation project

### A Question for Discussion:

• Your doctor wants to know.....

• ***What do I need to know about you as a person to give you the best care possible?***

### What do people say they want?

- To not be a burden
- To maintain some control
- To not be in pain
- To have time to share and reach closure
  
- Peace of mind may be *more* important than what medical treatments are given or not given

## BEING THE DECISION MAKER

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What are common challenges of being a decision maker for someone with dementia?

### Making Informed Decisions

- Focus on the person's wishes
- Stay true to the person's values and beliefs
- Weigh pros and cons of treatments
- Understand the difference between withholding treatment and Medical Aid-in Dying



### Questions to ask the doctor about end-of-life-care

- What is the treatment for?
- How will it help?
- What are the physical risks or discomforts?
- What are the emotional risks or discomforts?
- Does the treatment match what the person would have wanted?
- Are we doing all we can to uphold dignity?
- Are we doing all we can to give the person the best quality of life?
- Is he or she in pain? What can be done to ease the pain?
- When is the best time to ask for hospice care?

### Advance Care Planning in Dementia

- Similar to ACP for everybody
  - What is most important at the end of life?
  - Can be a conversation in early dementia
  - May need to be asked by family through sharing history
- Discuss ranges of treatment intensity
  - Full treatment
  - Selective treatment
  - Comfort-focused treatment
- Identify how much Flexibility for the agent



### How do People with Dementia Die?

- Falls (and hip fractures)
- Infections
  - Sepsis
  - Pneumonia
  - Urinary tract infections
- Underlying diseases
  - Heart failure
  - Renal failure
  - Chronic lung disease
  - Strokes
  - ....

### Approach to Advance Care Planning in Early Dementia

- Early diagnosis, or even before diagnosis
  - Lose some memory of recent events
  - Routine tasks become more difficult (cooking, driving)
- Advance Care Planning Steps:
  - Upstream conversations about Values and Wishes
  - Choosing your decision-maker; completing an MDPOA
  - Think about goals:
    - Live as long as possible
    - Treatment to prolong life but no resuscitation or intubation
    - Comfort-oriented care only

### What is the ability to make a decision?

- Able to communicate
- Understand care choices
- Share the consequences of those choices
- Explain why you are making the choice you are making
- *Not all-or-nothing*
- *Varies over time*
- *Not the same as legal "competence"*

### Approach to Advance Care Planning as Dementia Progresses:

- Middle Dementia or Moderate Dementia
  - Think about small parts of ACP at a time
  - Have family conversations
    - Reflect on prior discussions of values
    - Support the agent
- Again reflect on the person's overall goals for life
- Recognize that the agent will have a larger role in decision making

### Approach to Advance Care Planning in Advanced Dementia:

- Late-stage dementia
  - How did she live her life?
  - What was important to her?
  - How did she react to other deaths?
  - What would she say if she were sitting next to us now?



### Is Medical Aid-In-Dying an Option in Dementia?

No, not legal in dementia.

Patients Must:

- Be 18 years or older
- Demonstrate residence in Colorado
- Be capable of making and communicating their own health care decisions
- Have a terminal diagnosis; prognosis six months or less

### A Question for Discussion:

• Your doctor wants to know.....

• ***What do I need to know about you as a person to give you the best care possible?***

### Breaking the Ice or Next Steps

#### HOW DO YOU TALK ABOUT THIS?

- We often don't talk about plans for dying due to:
  - not understanding
  - not knowing wishes or situation
  - being uncomfortable with topic
  - wishing to protect others from uncomfortable situations.

### Thoughts on Starting Conversations

- Talk Early – It's NEVER Too Soon!
  - Encourage everybody you care for as a professional
  - Fold in all "interested persons"
  - Pivot off of news, personal experiences

Over half of older adults will not be able to participate in healthcare decisions near the end of our lives!

## Navigating Family Conflicts

- Prevention:
  - Conversations help avoid confusion/ guilt/ uncertainty
    - Keep loved one at center of conversations.
    - Be open / communicate
    - Have loved one pick MDPOA
- Out of town family
- Conflicting goals or beliefs of family members
  - How to come to resolution or a way forward?
- [Do you want an autopsy, examination of brain.]

## CONCLUSIONS

- Early conversations about values and wishes are critical.
- Dementia doesn't automatically rob a person of their ability to make or give input into decisions.
- Discerning values after the person loses capacity can be difficult, but can also represent a time when loved ones come together.
- It is very important to recognize overarching "goals and values" to make intervention decisions, since the benefit vs. burden balance changes.

## Colorado Care Planning



Website to help Coloradans find information for future medical planning, including choosing a medical decision maker.

<p><b>ROADMAP</b></p> <p>Follow this roadmap for guidance through the advance care planning process. Each stop along the way provides you with information to help you choose which steps and documents are</p>	<p><b>WHAT IF I...</b></p> <p>Everyone has their own personal journey, and often our journeys have different needs. Check out this page for tailored resources on what makes you, you. For example, "What if I am a Veteran"</p>	<p><b>COLORADO COMMUNITY RESOURCES</b></p> <p>Advance care planning may bring up additional topics such as housing, caregiving and insurance. Use this page to find resources near you such as</p>

<https://coloradocareplanning.org/>

## Handouts & Websites

- Colorado specific: [www.ColoradoCarePlanning.org](http://www.ColoradoCarePlanning.org)
- Conversation Project:
  - [www.theconversationprojectinboulder.org](http://www.theconversationprojectinboulder.org)
- Dementia Directive: [www.dementia-directive.org](http://www.dementia-directive.org)
- POLST information: [www.POLST.org](http://www.POLST.org)