

Community Based Patient Centered Advance Care Planning Intervention

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Presentation to LIFE at UCF

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Life Sustaining Treatments Snapshot

General Belief

- I want to be in charge of my own decisions
- I have plenty of time to complete Advance Care Planning
- If I have a Living Will the hospital won't follow it
- My family loves me and knows what I want

Reality

- Many will lose the ability to self-determine
- Terri Schiavo was 27 when she suffered a full cardiac arrest
- At times a Living Will was not followed, this can be avoided
- Family feel guilt and stress, and demonstrate dissonance with patients wishes

Institute of Medicine Report

Some are more prepared than others:

- ✓ Whites
- ✓ Older and chronically ill

HC Providers are poor communicators

Timing and environment for decisions

Health Literacy is a factor

Lack of planning linked to higher costs

Purpose

- Determine whether a Patient Centered Advance Care Planning Intervention could feasibly be provided to a community dwelling adults aged 65 and older, and their health care surrogates; and determine whether they find it acceptable.
- Congruence within the dyad on planner's preferences for life sustaining treatments

Methods

- Recruit 30 planner/surrogate dyads
- Provide the First Steps Advance Care Planning Intervention
- Allow 2 months contemplation/preparation
- Meet with Dyad for the last time
- Gift card to each person each time

Dissemination of Findings

- Inform a grant proposal resubmission for an R-21
- Come back to LIFE and present
- Publish/inform practice

Reflection

