ABC'S OF ADVANCE CARE PLANNING

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DISCLOSURES

None to report

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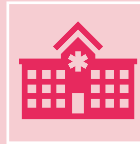
Objective



Define advance care planning, goals of care conversations, and how to document patient preferences

BE OPEN

BE READY

BE HEARD

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Donald and Cheryl

- You've been following Don for 5 years as his PCP
- Don is a 67-year-old with a history of coronary artery disease s/p 3-vessel bypass 7 years ago; he also has a history of type 2 diabetes on oral medications and hypertension, both well-controlled
- You referred him to a neurologist to confirm your suspicion for symptoms of Parkinson's disease, and he presents today in follow up along with Cheryl, his wife of 40 years
- Don has been formally diagnosed with Parkinson's. While he's a little worried about his new diagnosis, he shares that he's an optimistic person and he knows Michael J. Fox has lived for many years with this illness.
- Cheryl shares that she's feeling more worried, as Don just retired and they had hoped to start traveling more and spend more time with their adult children and grandchildren, some of whom live out of state

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In an ideal world with lots of time, what do you want to know? And is this the right time to explore further?

- What is Cheryl worried about? Do they have any questions about treatments or the diagnosis?
- Who would Don want to make medical decisions for him if he couldn't speak for himself?
- Does Don want to know his prognosis?
- Do Don and Cheryl want to know about what their future with Parkinson's disease looks like? Are there any aspects of that they're worried about?

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"Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding **future** medical care.

The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.

For many people, this process may include choosing and preparing another trusted person or persons to make medical decisions in the event the person can no longer make his or her own decisions."

- Consensus Delphi panel definition (Sudore et al. 2017)

Where do I start?

The good news is, you know many of your patients well and may know how they approach their medical care and who is important to them

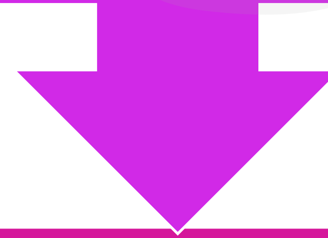
- If you don't know them, try to spend 5-10 minutes taking a life history to get to understand who they are (or get help from your team/colleagues if you have support)

Try to identify what their minimum acceptable quality of life is, and major values/goals.

Several patient-centered guides exist to help– The Conversation Project, Five Wishes Project, Prepare for Your Care

Goals of care

Hopefully, you can identify important values and what matters most to patients and their loved ones



After these discussions, you can advise of risks vs. benefit for interventions to help determine what types of medical care they DON'T want

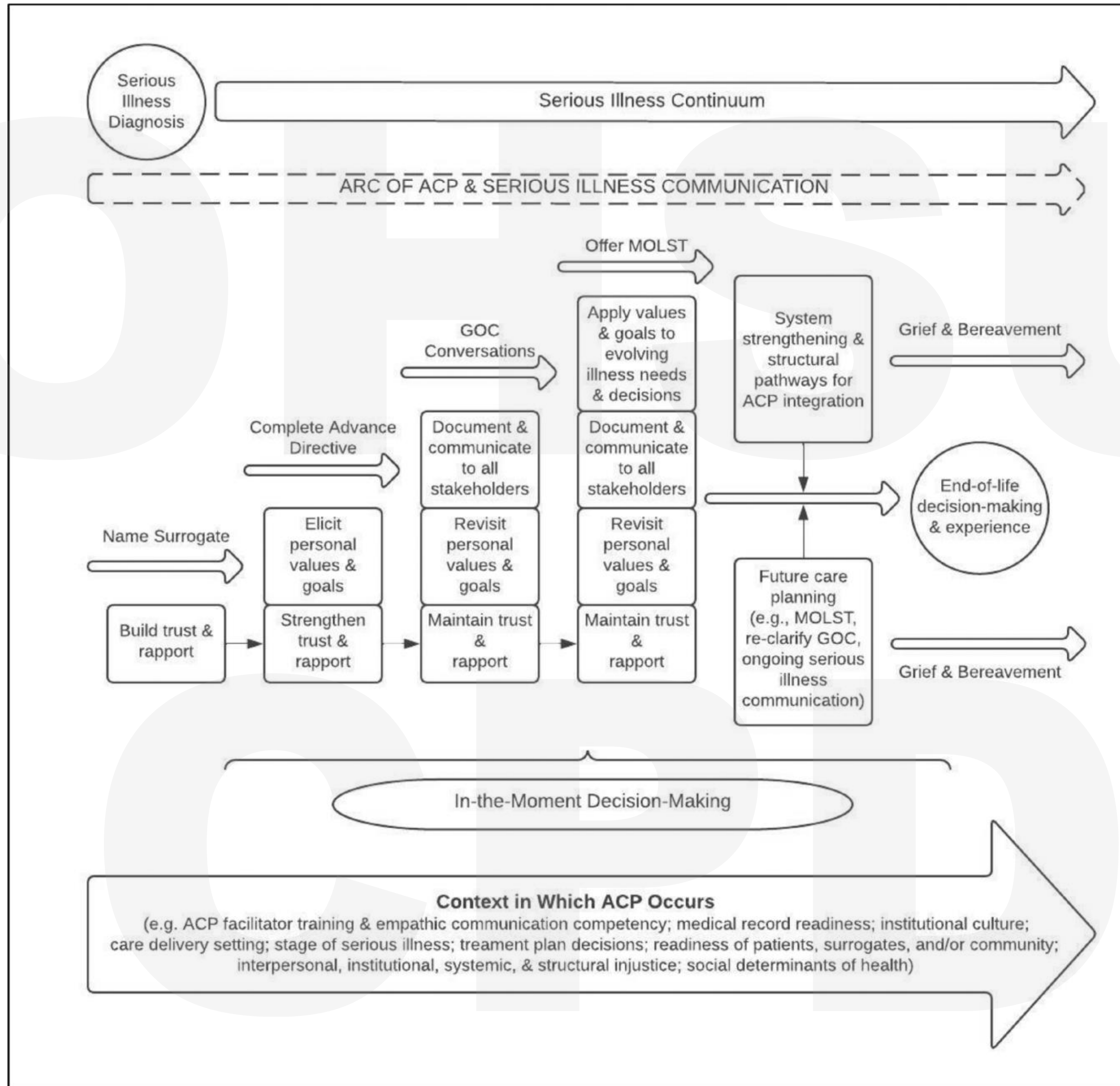


Figure 1. Advance Care Planning in Serious Illness: A Narrative Review
Rosa, William E. et al.
Journal of Pain and Symptom Management, Volume 65, Issue 1, e63 - e78

Don and Cheryl 3 years later

- Don presents after an ER visit where he was diagnosed with a rib fracture after a fall
- His neurologist believes he has Lewy Body Dementia now, and he's had some hallucinations that are mostly not bothersome
- Cheryl shares that she wants to be prepared for the next stages of Don's illness, and Don nods his head in agreement
- How do you make the most of the visit today?

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Communication trainings

TalkOregon

Respecting Choices®
PERSON-CENTERED CARE

Respecting Choices is a well-established, not-for-profit organization committed to guiding organizations and communities as they integrate and disseminate best practices to ensure that individuals' preferences and decisions for healthcare are *known and honored*.

Implementing effective systems for advance care planning (ACP) and shared decision-making (SDM) requires much more than conversation skills. The following unique abilities of Respecting Choices meet these additional needs.

EVIDENCE-BASED SKILLS TRAINING COURSES

VitalTalk makes healthcare communication skills *learnable*

Communicate more clearly, confidently, and compassionately with patients.

Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

SET UP

"I would like to **talk together** about what's happening with your health and **what matters to you. Would this be ok?"**

ASSESS

"To make sure I share information that's helpful to you, can you tell me **your understanding** of what's happening with your health now?"

"How much **information about what might be ahead** with your health would be helpful to discuss today?"

SHARE

"Can I share my understanding of what may be ahead with your health?"

Uncertain: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time, and we will work toward that goal. **It's also possible that you could get sick quickly**, and I think it is important that **we prepare** for that."

OR

Time: "I **wish** this was not the case. I am **worried** that time may be as short as *(express a range, e.g. days to weeks, weeks to months, months to a year)."*

OR

Function: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time, and we will work toward that goal. **It's also possible that it may get harder to do things** because of your illness, and I think it is important that we prepare for that."

Pause: Allow silence. Validate and explore emotions.

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Code Status and CPR Outcomes

Table. Outcomes of In-Hospital Cardiac Arrest[a]

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		CPR Attempted				
			ROSC Achieved			
				Survival to Discharge		
Characteristic	Mortality When CPR Not Attempted	No ROSC, Mortality Despite CPR	Subsequent Death in Hospital	Severe Disability	Moderate Disability	Mild or No Disability
All patients	100	43	39	3	5	11
VT/VF	100	28	32	3	8	29
PEA/asystole	100	46	40	3	4	7

Abbreviations: CPR, cardiopulmonary resuscitation; PEA, pulseless electrical activity, ROSC, return of spontaneous circulation; VF, ventricular fibrillation; VT, ventricular tachycardia.

[a] All data reported as percentage of patients; data source, Girotra et al.[1]

Breu AC. Clinician-Patient Discussions of Successful CPR—The Vegetable Clause. JAMA Intern Med. 2018;178(10):1299–1300. doi:10.1001/jamainternmed.2018.4066 (data from Girotra et al. article cited)

HOW TO DOCUMENT PREFERENCES

Advance directive: options include **a state-specific advance** directive, or **one drafted by an attorney**

POLST: state-specific document for out-of-hospital medical orders like DNR and levels of care (comfort, hospitalization, ICU level)

- Most useful for patients with a limited lifespan (e.g. 1-2 years)

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a. **Terminal condition**

This is what I want if:

- I have an illness that cannot be cured or reversed

  AND

- My health care providers believe it will result in my death within six months, regardless of any treatments.

Initial one option only	
______	I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
______	I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
______	I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
______	I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

B. If I am diagnosed to be in an advanced phase of a terminal condition or in a permanent unconscious condition *(initial & date selection):*

I ***do*** want to have artificially provided nutrition
_____ *(initial)* _____ *(date)*
I ***do not*** want to have artificially provided nutrition
_____ *(initial)* _____ *(date)*

C. If I am diagnosed to be in an advanced phase of a terminal condition or in a permanent unconscious condition *(initial & date selection):*

I ***do*** want to have artificially provided hydration
_____ *(initial)* _____ *(date)*
I ***do not*** want to have artificially provided hydration
_____ *(initial)* _____ *(date)*

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HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

- Sample -

Oregon POLST®

Portable Orders for Life-Sustaining Treatment*

For Patient Education

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient's Last Name:	Suffix:	Patient's First Name:	Patient's Middle Name:
Patient's Last Name		Patient's First Name	

Preferred Name:	Date of Birth: (mm/dd/yyyy)	Gender:	MRN (optional)
	Date / of / Birth	☐ M ☐ F ☐ X	

Address (street / city / state / zip):

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***Unresponsive, pulseless & not breathing.***

■ **Attempt Resuscitation/CPR**
Must check Full Treatment in Section B.

■ **Do Not Attempt Resuscitation/DNR**
If patient not in cardiopulmonary arrest, follow orders in B.

B *Check One*

MEDICAL INTERVENTIONS: ***When patient has a pulse and is breathing.***

■ **Comfort Measures Only.** Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: Provide treatments for comfort through symptom management.

■ **Selective Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer to hospital if indicated.*** *Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.

■ **Full Treatment.** In addition to care described in Comfort Measures Only and Selective Treatment, use intubation, advanced airway interventions and mechanical ventilation as indicated.
Transfer to hospital *and/or intensive care unit, if indicated.*
Treatment Plan: All treatments including breathing machine.

https://polstreg.com/login

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial

Date of Birth ___ ___ ___

Last 4 #SSN (optional) ___ ___ ___ ___

FIRST follow these orders, THEN contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a POLST form is always voluntary. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A — Check One

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
When not in cardiopulmonary arrest, go to part B.

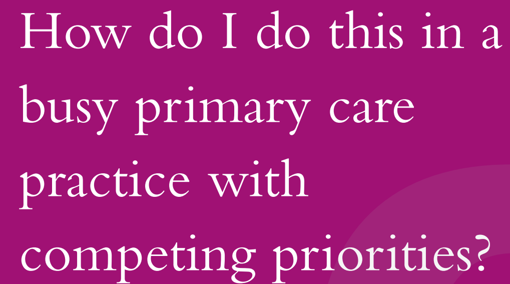
- ☐ Attempt Resuscitation/CPR
- ☐ Do Not Attempt Resuscitation/DNAR (Allow Natural Death)
  Choosing DNAR will include appropriate comfort measures.

B — Check One

MEDICAL INTERVENTIONS : Person has pulse and/or is breathing.

- ☐ **FULL TREATMENT** - primary goal of prolonging life by all medically effective means.
  Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. **Transfer** to hospital if indicated. Includes intensive care.
- ☐ **SELECTIVE TREATMENT** - goal of treating medical conditions while avoiding burdensome measures.
  Includes care described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Avoid intensive care if possible.
- ☐ **COMFORT-FOCUSED TREATMENT** - primary goal of maximizing comfort.
  Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional Orders: (e.g. dialysis, etc.) ____________________



How do I do this in a busy primary care practice with competing priorities?

Plan to spend 12-15 minutes as part of a visit

Determine who may benefit during a huddle, or plan for follow-up visit dedicated to advance care planning or goals of care discussions

Share the task between team members, if you have support (e.g. nursing, social work)

Your patients may be ready to have these conversations, and they usually appreciate them

As difficult as it can be-- slowing down, allowing silence, and acknowledging emotion can save time in the long run

Note on billing

Advance care planning codes are eligible if face-to-face (e.g. in person, video telehealth)

Can be billed alone if this is the entire focus of a visit, or added onto an office visit code–

99497– advance care planning 30 minutes= 1.5 RVU

99498– advance care planning additional 30 minutes= 1.4 RVU

Questions?

I want to thank my colleagues at the VA and OHSU for their contributions to this presentation and their work in serious illness care.