ADVANCE CARE PLANNING: IT'S A CONVERSATION ESPECIALLY WITH SERIOUS ILLNESS
DISCLOSURE

- I HAVE NOTHING TO DISCLOSE BUT WOULD LIKE TO
OBJECTIVES

- Define advance care planning
- Discuss impact on care
- What should be part of ACP and when should it happen - *its a conversation*
- COVID and it's impact and resources
Ms. DK

- Other history
  - Dementia
  - Stroke in past
  - Wheel chair bound
  - Had been on hospice in the past
  - POLST available
  - Daughter at bedside
  - Pleasant but speaks in word salad
DK

- TPA protocol began, includes blood work, emergency CT scan, cardiac monitoring
- Neurology alerted by ER per protocol
- Daughter calls primary care provider for advice
Primary care MD speaks to neurology and comes to the ER
Nurses upset when told to not continue stroke protocol
POLST at patient’s bedside
ER doctor informed of patient’s functional status which he stated he did not know what her functional status was prior to “stroke”
History of Advance Care Planning

- 1960s – DNR, no choice
- 1983 – Nancy Cruzan, Supreme Court definition of ADs, Artificial N and H
- 1990 – PSDA
- 1990s – POLST paradigm started
- 1996 – how we die in America
- 2006 – how we die in America
- 2020 - COVID
What we’ve learned

- A lot
- It’s about the conversation
- It’s not about DNR
- It’s not about a check box
- It’s about a system
- How to have to conversations – lots of tools, pick one that works for you and your organization
Still learning

- When a decision is needed patients are often unable
- ACP when done well works – less likely to die in the hospital, less likely to get all care possible
- For ACP to work you need a system
- COVID has changed the environment in many ways
What we still need to learn

- Providers and system issues
  - Limited training
  - “limited time”
  - Poor documentation and review
  - Conversations remain limited to DNR
  - Lack of understanding value
  - IT’S A PROCESS
“I’m going to send you to someone who’s not afraid of doing a little harm.”
Who should have an ACP

- Any one over the age 18!!
- Really?
- Certainly over the age of 65
- Seriously ill – ACP and POLST
- Conversations even more important in current climate
IT’S A BRAVE NEW WORLD – COVID has changed this

- 94 yo woman, hospitalized twice in one month, was living alone and wants to go home. Son is convinced she has many good years

- 96 yo woman who was told by an MD that she may have less than a year to live because of possible cancer, daughter wanted to sue physician because of that
My Old Mentor

- WE LIVE IN A WORLD OF THE TEMPORARILY IMMORTAL

- Joanne Lynn
COVID EFFECT

- We are all affected.
- People dying without family, without important traditions
- Limited access to care
- Who is doing grief and bereavement care
- Conversations are happening over the phone
Models – pick one for ACP

- Prepareforyourcare.org
  - Choose a medical decision maker
  - Decide what matters most in life – 5 questions
    - What is most important in your life
    - What experiences have you had with serious illness or death
    - What brings you quality of life
    - If you were very sick, what would be most important to you
    - Have you changed your mind about what matters
Prepare for your care (cont)

- Choose flexibility for your decision maker
- Tell others about your medical wishes
- Ask doctors the right questions
  - Benefits
  - Risks
  - Other options
  - What would your life be like after treatment
- Then do a document
Models for conversation

- The Conversation Project
- Similar to Prepare
- Gives specific phrasing for talking to family
- Theconversationproject.org
The Stanford Project

- Starts with a letter
- Produces an advance directive
- Again emphasizes conversation
Conversations about serious illness – when to have them

- The Surprise Question
  - Would you be surprised if patient died in the next year? Surprisingly predictive

- Multiple hospitalizations
- New life threatening diagnosis
- There are multiple models for this
SPIKES – 6 steps

- S – setting up the interview – what, where, who, intros
- P – patients perception
- I – invitation, what does the patient want to know
- K- giving knowledge and info to patient
- E – addressing emotion
- S – strategy and summary
Serious illness conversation guide

- Set up the conversation
- Assess understanding and preferences
- Share prognosis
- Explore key topics – goals, fears, worries, sources of strength, abilities tradeoffs, family
- Close the conversation – summarize, make a recommendation, check in with patient, affirm commitment
- Document
Serious illness

- Language matters
- Silence matters
- I’d like to talk about what is ahead with your illness and do some thinking in advance so that I can make sure we provide you with the care you want
- IS THIS OK?
COVID RESOURCES

- CAPC- HAS EXTENSIVE TOOL KIT INCLUDING SYMPTOM MANAGEMENT
- PREPAREFORYOURCARE.ORG
  - SPECIFIC SCRIPTS FOR TELEMEDICINE WITH PATIENTS ABOUT ADVANCE DIRECTIVES
  - SPECIFIC HANDOUT FOR FAMILIES ABOUT HOW TO PREPARE FOR GETTING ILL WITH COVID
POLST VERSUS ADVANCE DIRECTIVES
## POLST vs Advance Directive

<table>
<thead>
<tr>
<th>Type of document</th>
<th>Medical order - POLST</th>
<th>Legal document, goals - AD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who completes</td>
<td>Provider and patient or surrogate</td>
<td>Individual</td>
</tr>
<tr>
<td>Who needs one</td>
<td>Seriously ill or frail, surprise question</td>
<td>All competent adults</td>
</tr>
<tr>
<td>Appoints a surrogate</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>What is communicated</td>
<td>Specific medical orders</td>
<td>General wishes about treatment, a guide</td>
</tr>
<tr>
<td>Can EMS use</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ease in locating</td>
<td>Easy to find, in chart, patient has original</td>
<td>Depends</td>
</tr>
<tr>
<td>Signatures</td>
<td>Provider, patient or SDM</td>
<td>Varies from state to state</td>
</tr>
</tbody>
</table>
POLST – the seven deadly sins

- Using the POLST with people who are too healthy
- Signing a POLST without meaningful discussion with patient and SDM
- Having patients complete their own POLST form
- Providing incentives for completing more POLST forms
Seven sins continued

- Failing to review POLST forms
- Letting POLST disappear
- Failing to evaluate your use of the POLST paradigm
COVID AND ITS IMPLICATIONS

- Palliative care – should be a part of every command center (CAPC)
  - However, not enough of us
  - Not seen as a priority
  - Not just having an advance directive, having a conversation
  - Importance of symptom management
  - Hospice – being restricted in multiple settings
  - Families – not being able to be with families
COVID Resources for Palliative care and hospice workers

- Many of them out there
- PC NOW – PALLIATIVE CARE NETWORK OF WISCONSIN
- COVID prepareforyourcare
- CAPC
- Check it out – it’s free
CALMER – COVID ready communication playbook

- C – check in, how are you doing with all this
- A – ask about COVID
- L – Lay out issues
- M – motivate to choose a proxy, back up person, talk about what matters
- E – expect emotion
- R – Record, any documentation, can be brief
FINALLY

- ADVANCE CARE PLANNING IS KEY
- DISCUSSIONS ARE BILLABLE
- HOW TO FIND TIME
- MAKE IT A PRIORITY
- DOCUMENT
- DO A SPECIAL VISIT JUST FOR THIS
- USE OTHER RESOURCES
- TAKE CARE OF YOURSELF
WHAT MATTERS TO THE PATIENT IS AS IMPORTANT AS WHAT IS THE MATTER WITH THE PATIENT

It is about the conversation

But it is also about a commitment from all involved. That includes patient, SDM, family, providers and systems