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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

DK

- 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"

Search

at Matters Most...
NNING: MORE
-CHECKING
iyakol, MD

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 Its 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 then 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

Prepareforyourcare (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 a 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

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

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