ADVANCE CARE PLANNING

WHAT WHY WHEN & HOW

WHAT IS ADVANCE CARE PLANNING

Advance Care Planning:

- Facilitated conversations between patients, loved ones and healthcare agents
- Reflects on goals, values and beliefs
- Discusses those goals, values and beliefs in relation to possible healthcare choices
- Communicates the plan for choices to others

WHAT ADVANCE CARE PLANNING IS NOT

- It is not a **code status** conversation- code status will be a natural by product of an Advance Care Planning Conversation
- It is not your **regulatory care plan**- patient centered goals of care will be a natural by product of an Advance Care Planning Conversation
- It is not a **document**- a DPOA/Living Will/Portable Orders may be a natural by product of an Advance Care Planning Conversation and
  ALL Advance Care Planning conversations must be documented in an easily accessible location for ALL facility staff to review.

WHY DO ADVANCE CARE PLANNING AT YOUR FACILITY

- Regulatory Requirements
  - Patient Self Determination Act 1991
  - COP for LTC-§483.10(c)(6), (c)(8), (g) (12)-"Advance Care planning" is a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions.
- Comprehensive Patient Centered Care Plans
  - Advance Care planning is an integral aspect of the facility's comprehensive care planning process and assures a re-evaluation of the resident's desires on a routine basis and when there is a significant change in the resident's condition.
  - Assessment- the resident must receive a comprehensive assessment to provide direction for the development of the resident's care plan to address the choices and preferences of the resident who is nearing end of life… **initiate discussions/considerations regarding advance care planning and resident choices to clarify goals and preference regarding treatment including pain management and symptom control, treatment of acute illness, and choices regarding hospitalization.**
  - Care Plan: the care plan must be based upon the resident assessment, choices and advance directives, if any.
- PTAC

WHY DO ADVANCE CARE PLANNING AT YOUR FACILITY

- General population: 2013 analysis of a Health Styles Survey(national survey sent out from all 7 census bureaus) found 26.3% 18 & older of the respondents had an Advance Directive-of those with an AD, 51.2% were 65 or older and only 11.8% of those 18-34 had an AD
- When interviewed w/in 30 days of death, only 31% of patients and 52% of caregivers believed the patient had less than one year to live.
- 80% think ACP is important, only 25% have recorded their wishes
- < 50% have talked to their family about their wishes
- Only 11.9% preferred life-prolonging care

References 1,2,3,4

WHY DO ADVANCE CARE PLANNING AT YOUR FACILITY

- 90% think talking to their doctor is important, only 20% have actually done so.
- 89% of HCP think ACP conversations are important and 75% of doctors say its their responsibility.
- Physicians tend to overestimate survival, even in patients with known terminal conditions.
- Over 50% of doctors report they are uncomfortable having these conversations

References 1,2,3,4

WHY DO ADVANCE CARE PLANNING AT YOUR FACILITY

- Agreement between EOL preferences and the EMR documentation was 30.2%
- When documentation exists, clinicians often don't notice it
- Wishes captured in legal documents are not always translated into actionable medical orders, leaving HCP uncertain abut what actions to take in a medical crisis

References 1,2,3,4

WHY DO ADVANCE CARE PLANNING AT YOUR FACILITY

Results in unnecessary harm and suffering

INCREASED QUALITY

Reduction of **$11-20** (estimated) million annually

DECREASED HEALTHCARE COSTS

Decrease of resident hospital deaths from 22% to 8%

REDUCED UNNECESSARY TRANSFERS

WHY DO ADVANCE CARE PLANNING AT YOUR FACILITY

"For certain patient populations, ACP is particularly important. The risk of harm is elevated and more apparent in patients with serious illness or older age. As a consequence of their conditions, such patients have an increased risk of death, and may also have an increased risk of potentially harmful events such as hospitalizations, loss of capacity, loss of independence, or loss of identity. …failure to conduct appropriate ACP could be considered negligent, resulting in unnecessary suffering and harm." (for both residents and families)

Allergy Analogy: "Providing care w/o engaging in conversations about EOL care wishes & delivering care inconsistent w/ patients' stated wishes were on par with medical errors."

(Dr. Lachlan Forrow, Director of Ethics and Palliative Care, Beth Israel Deaconess Medical Center)

Reference 4

WHEN TO DO ADVANCE CARE PLANNING AT YOUR FACILITY

- On Admission, with every person that comes into your facility
  - Normalize this process
  - Set expectations with residents/families
  - Make it part of your admissions routine
- Change In Condition
- Return from hospital
- Resident/family voice concerns for what is happening
- Annually

SCENARIO

96 y/o female with a past medical history of: dementia, macular degeneration, syncope, GERD and arthritis. Resides at a nursing facility for the last year after transitioning from an assisted living following a fracture. She is alert- no incapacity noted. Son is involved in her care. He notes that her mental state is up and down, but she was recently able to play a board game and was fairly conversant. Code Status on admit is "no code" and has been that for quite some time prior to admission.

There have been no conversations re: goals of care other than code status discussion.

Resident falls out of bed and eLTC has been contacted. Nurse reports that resident has been declining and having multiple falls lately. She sustained a skin tear, abrasion/hematoma to forehead and nose bleed. She is typically more responsive than she is at the time of the call. Due to change in altered mental status and no prior goals of care conversations, she is sent to ED via ambulance.

In the ER, resident has knee pain and is somnolent. Physician speaks to son who wants to "limit testing to only emergently necessary tests." He is eager to get her back to familiar settings and she is sent back to facility.

1. How would have an ACP discussion helped in this situation?
2. How/when would you have started this conversation?

HOW TO DO ADVANCE CARE PLANNING AT YOUR FACILITY

- Advance Care Planning conversation are a specific skill set that can be learned and developed over time. Often, these conversations are held by a Palliative Care team in a hospital setting. This team is made up of specially trained:
  - Physicians
  - Providers
  - Nurses
  - Social Workers
  - Chaplains
  - Pharmacists

HOW TO DO ADVANCE CARE PLANNING AT YOUR FACILITY

Pre-requisite:

- Chart Review- know the patients condition. Has there been previous goals of care conversation at the hospital?
- Does the patient have capacity to make complex medical decisions? If not, who is the legal surrogate decision maker (DPOA or by state statute)
- Are there existing documents and what do they say/when were they done. They may add useful insight
- Consider using a values clarification worksheet to use during your conversation. It would be completed prior to the meeting.

HOW TO DO ADVANCE CARE PLANNING AT YOUR FACILITY

Who Should Be Involved In The Conversation?

- Facilitator (who will be the champion in your facility)
- Patient
- DPOA
- Family-is there someone in the family that needs to be there even if they aren't the DPOA?
- Spiritual/Cultural Leader
- Physician/Practitioner

(Being involved can be done via phone)

- Seek permission to have a goals of care conversation (needed for billing)
- Location, Location, Location
  - Amenities
- Always make sure everyone in the room has a chair- SIT DOWN- No DOORWAY DISCUSSIONS

HOW TO DO ADVANCE CARE PLANNING AT YOUR FACILITY

Elements of an ACP Conversation: C-A-R/R-E

- C-Clarify: Introductions/Rapport
  - Why are you there-consider scripting this
- A-Assess: Approach the visit as a conversation to elicit the patient's perspective, not merely dispensing information and acquiring a decision. First ask for, then LISTEN to the patient's perception of their medical situation as well as their values and goals of care.
  - Create your own phrasing that feels natural to you
  - Shared decision making
  - RULE OARS
- R-Respond: provide education to the patient/agent
  - Always ask permission to provide education- PAPA
- R-Reflect: Summarize what you've heard
  - What other information would be important
  - Further clarification needed
- E-Execute:
  - Document the conversation- billing requirements and communication
  - Care Plan to reflect new goals
  - DPOA/LIVING WILL/POLST;MOST/CODE STATUS

SCENARIO

85 y/o female with mild dementia recently diagnosed with pancreatic cancer with mets to the liver. The conversation with the oncologist included: a discussion of the natural course of the illness; prognosis and treatment options, including hospice care. Risk and benefits of chemo were also discussed and explained that survival with no further therapy is less than 3 months and at best a year with chemotherapy. Surgery and RXT are not an option. Comfort care was encouraged multiple times, but she wanted to proceed with chemotherapy. She is full code. Her husband was present at the conversation with the physician.

She was hospitalized shortly after her first round of treatment for weakness, nausea and now is coming to your facility for strengthening.

What are next steps?

What is important to find out?

REFERENCES

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