Palliative Care for Neurologic Diseases

- **Susan E. Nelson MD FACP FAAHPM**
- Internal Medicine/Geriatrics/Hospice and Palliative Medicine
- System Chair, Palliative Medicine and Supportive Care and Bioethics, **Ochsner Health**
- Medical Director, Palliative Care, Ochsner Health Network
- 1514 Jefferson Highway, New Orleans LA 70121
- P: (504) 842-0961 F: (504) 842-0090 C: (225) 907-5927
- Susan.nelson@ochsner.org

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Learning Objectives

- At the completion of this regularly scheduled activity, participants should be able to:
  - Define palliative medicine as “an extra layer of support for patients with serious illness and their families to improve quality of life”
  - Know why we all need to improve shared decision making in serious illness conversations
  - Complete the appropriate documents (living will, health care power of attorney, LaPOST, MS MOST)
  - Talk with other doctors and team members to create a roadmap for “providing the best care possible”

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What is palliative medicine?

- **An extra layer of support for patients with serious illness and their families to improve quality of life with the focus on:**
  - **Pain and symptom management**
  - **Navigating the health care system**
  - **Having and documenting conversations with patients and families on "What Matters Most". There are many tools and dot phrases in EPIC to accomplish this consistently.**
- **Palliative Medicine is provided in the inpatient, outpatient, post acute settings and in the home. ****
  - ***A focus on end-of-life spending is not, by itself, a useful way to identify wasteful spending.***
  - ***Instead, we must focus on quality of care for very sick patients—identifying the impact of specific health care interventions on survival rates and, just as importantly, on palliation of symptoms.***

- ****Predictive modeling of U.S. health care spending in late life L. Einave et al. *SCIENCE*** 29 Jun 2018 Vol 360,Issue 6396 pp.1462-1465 DOI: 10.1126/science.aar5045

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Top Ten List of Symptoms

- Nausea and vomiting
- Dyspnea and cough
- Constipation
- Anxiety
- Asthenia (weakness)
- Anorexia
- Insomnia
- Pruritus
- Seizures
- Pain

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What we know----

- Seriously ill patients who have conversations with their clinicians about their goals and wishes
  - are more likely to have better outcomes
  - fewer non-beneficial medical interventions,
  - and better quality of life.
- Most patients WANT to have these conversations yet less than one third of patients with life limiting illnesses report discussing their care goals and preferences with their clinicians.
- Let's Talk: Community Promotes the Conversation About End-of-Life Care Wishes (chcf.org)
- Ariadne Labs SICP

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Barriers to having these conversations

- Time constraints-MAYBE; the more you do the better you get!
- Lack of the necessary skills and confidence among clinicians-Lots of ways to learn this!
- Fear among clinicians that bringing up serious illness and end-of-life issues may be harmful to patients – OPPOSITE IS TRUE!
- Uncertainty among clinicians about when it is appropriate to have these conversations—ANY TIME is the right time!
- We have a duty to provide as much prognostic information as possible especially in acute devastating illness
- Confusion about who should initiate the discussion-EVERYONE should own this!
- Lack of systems to implement conversations and ensure quality and control-Ochsner has developed many enhancements in EPIC and has many educational courses.
- Shortage of palliative care specialists for the more difficult conversations-everyone should have primary palliative care skills!
- https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1916912

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Think of conversations as procedures….

- **Having a bad conversation is as damaging as cutting off the wrong leg!**

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We are already doing advance care planning
How is this different?

Advance Directive Practice	Advance Care Planning
Typically, a one-time event focused on educational materials	An ongoing conversation that begins upstream with adults who have not planned
Agents often are unprepared	Agents engaged in the process, allowing them to understand decisions and be prepared
Inconsistent ACP conversations occur	Standardized approach to ACP across all settings
Focused on the elderly and those with advanced illness	Routine part of person-centered care for all adults
Service delivery within palliative care or end-of-life care	Delivered in settings across the continuum of care
The focus is on document completion	The focus is on person-centered conversations that lead to alignment in plans of care

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Hargraves, I., LeBlanc, A., Shah, N. D., & Montori, V. M. (2016). Shared decision making: The need for patient-clinician conversation, not just information. *Health Affairs*, *35*(4), 627–629. https://doi.org/10.1377/hlthaff.2015.1354

Shared Decision Making: The Need For Patient–Clinician Conversation, Not Just Information

The growth of shared decision making has been driven largely by the understanding that patients need information and choices regarding their health care. But while these are important elements for patients who make decisions in partnership with their clinicians, our experience suggests that they are not enough to address the larger issue: ***the need for the patient and clinician to jointly create a course of action that is best for the individual patient and his or her family. The larger need in evidence-informed shared decision making is for a patient-clinician interaction that offers conversation, not just information, and care, not just choice.***

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Decision Making Framework
not “the DO YOU WANT US TO DO EVERYTHING” question

- Families perceive that “if you ask them if they want something” ---it is because it will help!
- Do not ask families if they want ***everything done*** unless you specify what “everything” is. Don’t be frustrated when they want “everything” you offered!
- To families---they want their family member cared for in the best possible way AND they are looking to you to recommend things that are appropriate.
- **RECOMMEND a course of treatment and tell them why some things are not available and will not work!**

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What is the evidence?

- **TRAINING CLINICIANS IN SERIOUS ILLNESS COMMUNICATION USING A STRUCTURED GUIDE**
- *"the streamlined and adaptable nature of this training suggests that this may be a scalable model to meet the goal of serious illness communication training for large numbers of health care professionals."*

  - *Journal of Palliative Medicine*, "Training Clinicians in Serious Illness Communication Using a Structured Guide: Evaluation of a Training Program in Three Health Systems," February 2020.

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What is the evidence?

- **TESTING THE SERIOUS ILLNESS CARE PROGRAM AT THE DANA-FARBER CANCER INSTITUTE**

- **Study preliminary findings:** Journal of Clinical Oncology, Abstract: Delivering more, earlier, and better goals-of-care conversations to seriously ill oncology patients, October 2015

- **Conclusion:** Our preliminary analysis indicates a brief communication skills training program for oncology clinicians, accompanied by simple tools and workflow changes, resulted in more, better and earlier serious illness conversations and reductions in anxiety and depression for patients with advanced cancer.

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What is the evidence?

- SERIOUS ILLNESS CARE IN AFRICAN-AMERICAN PATIENTS AND FAMILIES
- **Partners:** South Carolina Hospital Association, Medical University of South Carolina in Charleston, SC
- **What did we learn?**
- The study found that a conversation guide can help overcome barriers to advance care planning for a community that has historically been negatively impacted by health care experiences. The guide encourages direct communication, and the questions at the heart of the conversation are about hearing from the patient about their goals, values, and priorities. Focus group participants found the language used in the Guide easy to understand. **As a result of the study, an additional question was added to the Guide – "What gives you strength as you think about the future with your illness?"**

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What is the evidence?

- **HOW TO IMPROVE ADVANCED CARE PLANNING FOR AFRICAN AMERICANS**
- **Study results**: *Palliative and Supportive Care*, From Barriers to Assets: Rethinking factors impacting advance care planning for African Americans, April 2018.
- Advanced care planning (ACP) can provide clarity on critical end-of-life care issues by clarifying care preferences beforehand. African Americans do not participate in ACP as much as white Americans, which may impact their quality of life and cause challenges when they suffer serious illness. As part of a broader study to improve the quality of clinician-led ACP, researchers performed a qualitative study with a small group of health disparities experts, community members and seriously ill African American patients and caregivers to understand factors that limit or enable ACP.
  This study is the first to examine and compare these barriers and facilitators from multiple perspectives.
- **Seven factors emerged to deter or enable ACP among African Americans**:
  - religion and spirituality,
  - trust and mistrust,
  - family relationships and experiences,
  - patient-clinician relationships,
  - prognostic communication,
  - care preferences and
  - preparation and control.
- **Most importantly, African American patients said they desired respectful communication and a rapport with the medical professionals they work with, which is an important takeaway for increasing ACP.**

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What is the evidence?

- SERIOUS ILLNESS CARE IN THE PRIMARY CARE SETTING *Healthcare*, "A systematic intervention to improve serious illness communication in primary care: Effect on expenses at the end of life," June 2020
- **Conclusion:**
  - Overall, this primary palliative care intervention was feasible and endorsed by clinicians, and it improved discussions about patients' goals and values. By providing a comprehensive approach, including patient identification, teamwork and coaching, we have seen how beneficial this can be for both patients and providers. This intervention contributes to a new model for improving care for seriously ill patients in the primary care setting.
  - Programs that are designed to drive more, earlier, and better serious illness communication hold the potential to reduce costs (by providing only wanted treatments).

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What is the evidence?

- SERIOUS ILLNESS CARE FOR CHRONIC CRITICAL ILLNESS SETTINGS
- **Conclusion**: Patients reported an overly optimistic expectation for returning home and unmet palliative care needs, suggesting the need for integration of palliative care within the long-term acute care hospital.
  - Both patients and surrogates found this type of conversation acceptable, and the primary hospitalists reported the information to be useful and that it would affect clinical care decisions.
  - This suggests there is an opening to use the Conversation Guide to improve the conversations clinicians have with their chronically critically ill patients and surrogates, and to continue the discussions even when initial decisions may have already been made.

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What is the evidence?

- SERIOUS ILLNESS CARE IN EMERGENCY SURGERY SETTINGS
  - **Study Results:** Journal of Palliative Medicine, 2016; Annals of Surgery, 2016; Journal of Palliative Medicine, 2014.
- **Conclusion:** The group of experts identified the need for educational opportunities for surgeons to strengthen clinical communication skills for the serious illness setting, and the need to study the impact of such initiatives in improving patient outcomes.

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Decision Making Conversation Frameworks

- www.respectingchoices.org is being taught at Ochsner
- SERIOUS ILLNESS CARE - Ariadne Labs
  - embedded in ACP module in Ochsner EPIC
- https://www.vitaltalk.org/vitaltalk-apps/
- https://www.mypcnow.org/ Fast Facts app link at the bottom right of the page
- PREPARE (prepareforyourcare.org)
- The Conversation Project - Have You Had The Conversation?

VITAL talk

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Ariadne Labs/Serious Illness Conversation Program

SERIOUS ILLNESS CARE PROGRAM - Ariadne Labs

- Patients/families
  - Significant improvements in patient outcomes
  - More conversations about values and goals (89% vs. 44%) and prognosis (91% vs. 48%).
  - Conversations earlier in the illness course (5 months vs. 2.5 months before death).
  - More accessible documentation of patients' goals in the medical record (61% vs. 11%).
  - Reductions in moderate to severe anxiety (10.2% control vs 5.0% intervention) and depression symptoms (20.8% control vs 10.6% intervention).
  - Positive experiences for patients
  - 80% of patients found the conversation worthwhile.
- Patients reported:
  - Better communication with their families: "It gave me focus, and I felt relieved after I spoke about some difficult stuff with them."
  - More planning for the future: "…[I am] more focused on goals I want to accomplish."
  - Enhanced planning for medical care: "…When I can no longer go [to the] bathroom by myself, I would like hospice house care."
  - Feeling closer to their clinician: "Mostly, the conversation brought us closer."

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CONVERSATION FLOW
PATIENT-TESTED LANGUAGE

1. Set up the conversation

- Introduce purpose
- Prepare for future decisions
- Ask permission

"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"

2. Assess understanding and preferences

- "What is your **understanding** now of where you are with your illness?"
- "How much **information** about what is likely to be ahead with your illness would you like from me?"

"I want to share with you **my understanding** of where things are with your illness..."

- *Uncertain:* "It can be difficult to predict what will happen with your illness.

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3. *Share prognosis*

- Frame as a “wish…worry”, “hope...worry” statement
- Allow silence, explore emotion

- I **hope** you will continue to live well for a long time but I’m **worried** that you could get sick quickly, and I think it is important to prepare for that possibility.” OR
- *Time:* “I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g., days to weeks, weeks to months, months to a year).*” OR
- *Function:* “I **hope** that this is not the case, but I’m **worried** that this may be as strong as you will feel, and things are likely to get more difficult.”

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4. *Explore key topics*

- Goals
- Fears and worries
- Sources of strength
- Critical abilities
- Tradeoffs
- Family

- "What are your most important **goals** if your health situation worsens?"
- "What are your biggest **fears and worries** about the future with your health?"
- "What gives you **strength** as you think about the future with your illness?"
- "What **abilities** are so critical to your life that you can't imagine living without them?"
- "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?"
- "How much does your **family** know about your priorities and wishes?"

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5. *Close the conversation*

- Summarize
- Make a recommendation
- Check in with patient
- Affirm commitment

- "I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness,
- I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you."
- "How does this plan seem to you?"
- "I will do everything I can to help you through this."

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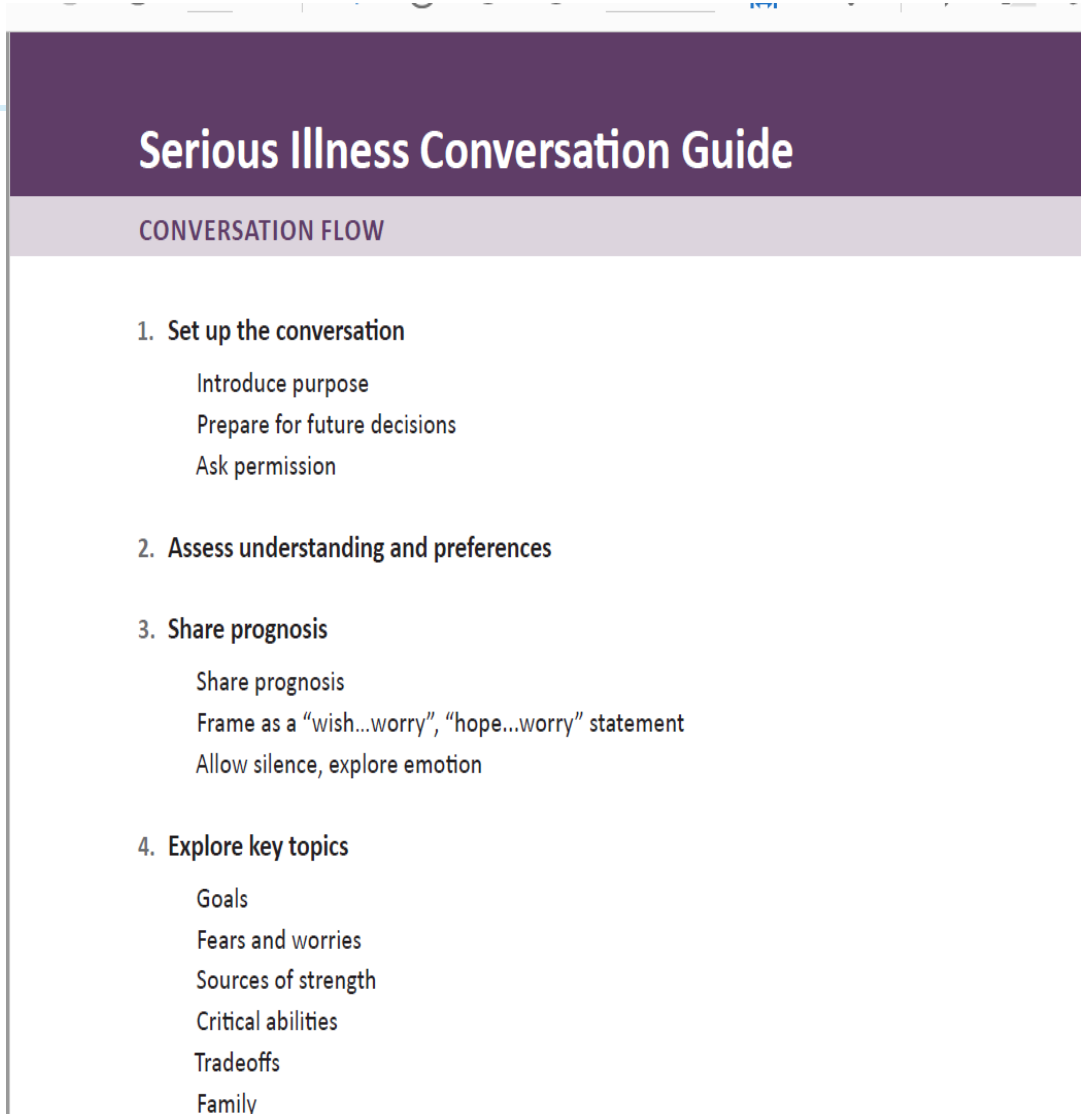
Serious Illness Conversation Guide

- Ariadne labs
- Evidence based conversation in the setting of serious illness



Serious Illness Conversation Guide

CONVERSATION FLOW

1. **Set up the conversation**
   - Introduce purpose
   - Prepare for future decisions
   - Ask permission
2. **Assess understanding and preferences**
3. **Share prognosis**
   - Share prognosis
   - Frame as a "wish...worry", "hope...worry" statement
   - Allow silence, explore emotion
4. **Explore key topics**
   - Goals
   - Fears and worries
   - Sources of strength
   - Critical abilities
   - Tradeoffs
   - Family

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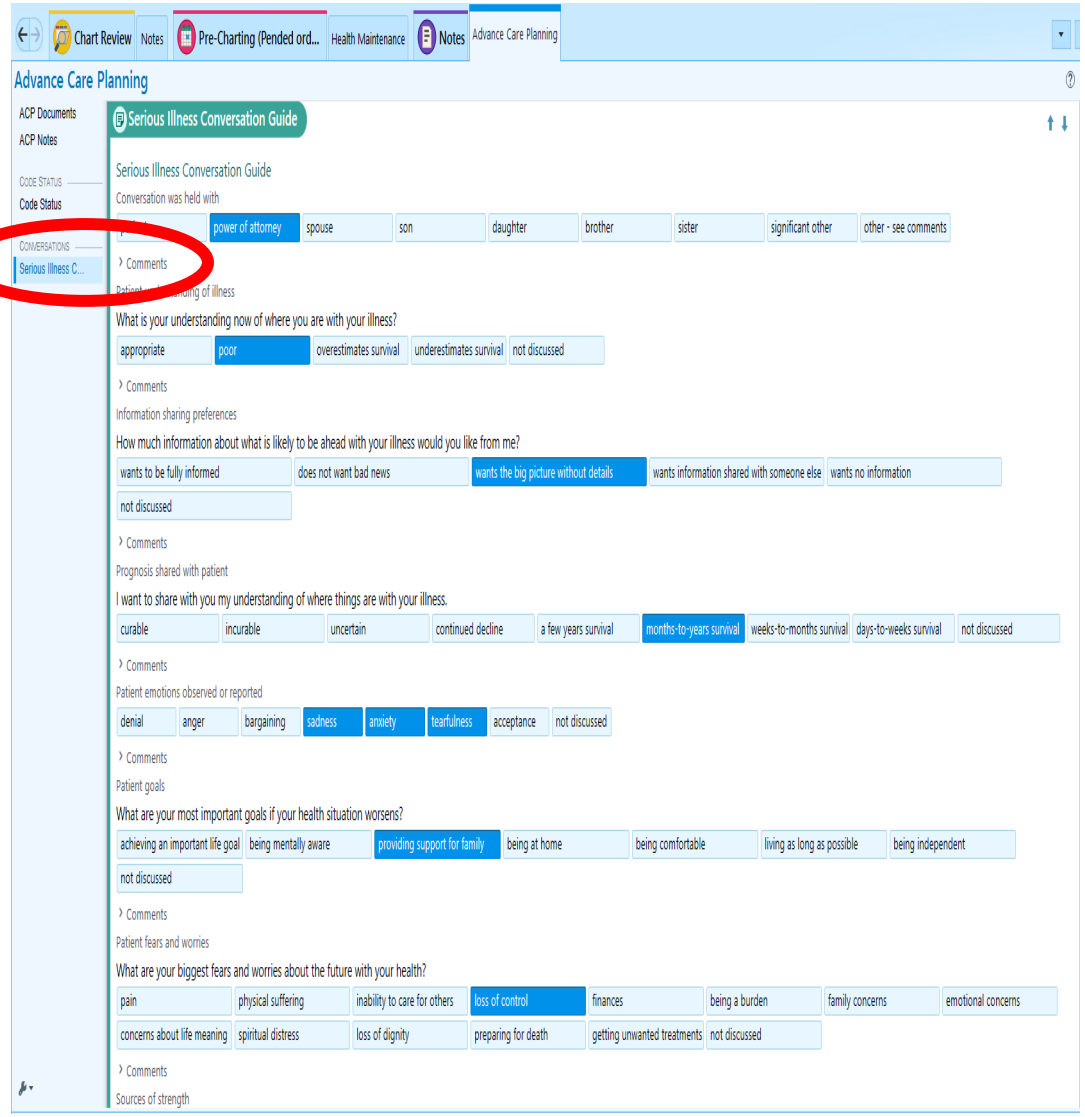
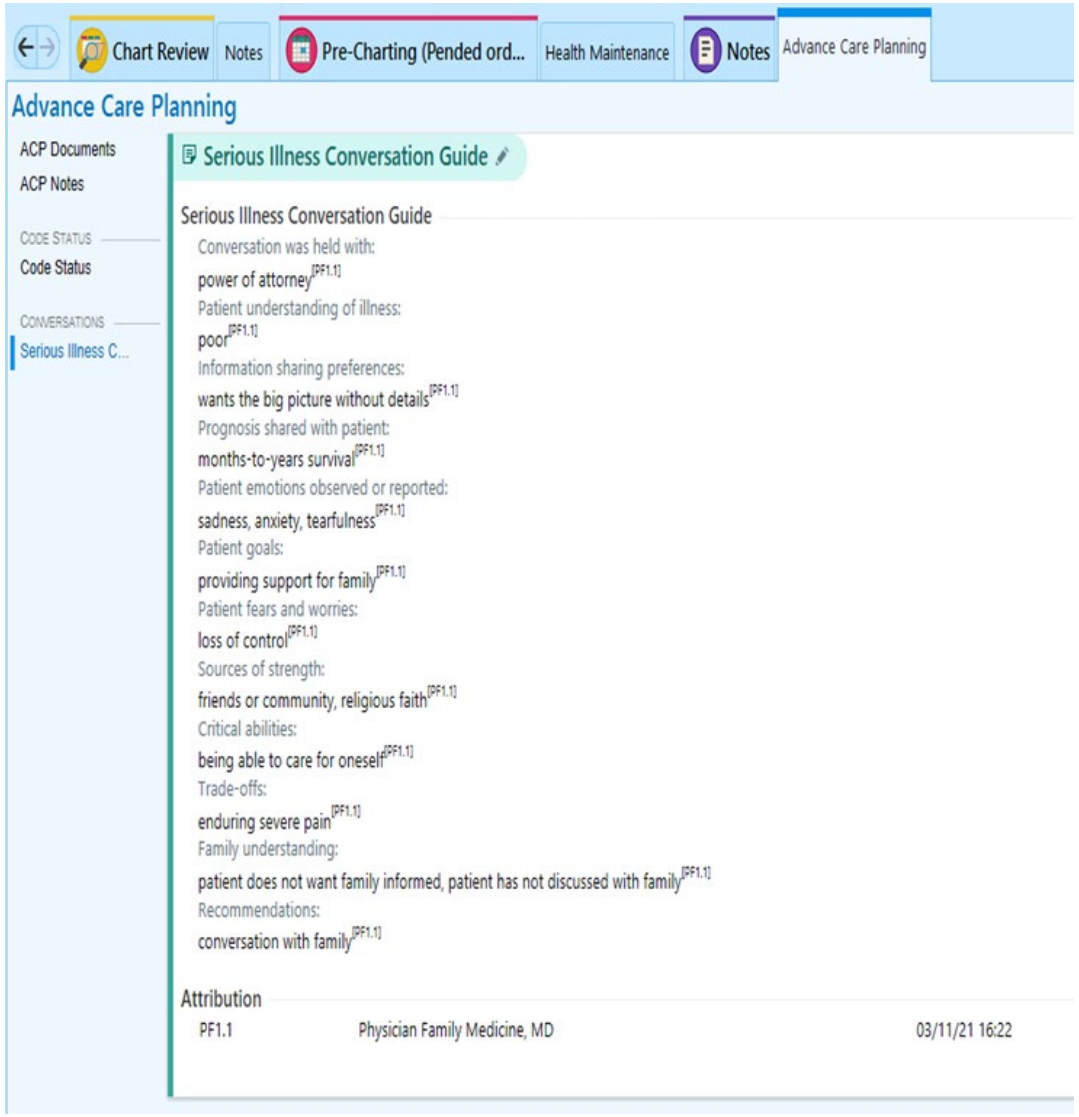
Serious Illness Conversation Guide (.seriousillnessconversationguide)





Don't forget……

Document the conversation

Communicate with key clinicians

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How to Start the Conversation about Advance Care Planning

Item: 56266
Revised: 06/2018

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Want more information?
Scan this QR code to
watch our video.

Want to learn more?
Scan this QR code to
read our online booklet.

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- www.lhcqf.org/images/LaPOST-Images/Guide-to-Advance-Care-Planning.pdf
- www.nia.nih.gov/health/publication/advance-care-planning

Ochsner Advance Care Planning video
https://youtu.be/wUAiTlgEVvU

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Thank you!

This is really important work!

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- Appendix

Serious Illness*

- Cancer
- Heart failure
- Lung failure (COPD/emphysema)
- Liver failure
- Kidney failure
- Frailty – “dwindles”
- Brain failure which complicates all and is associated with highest risk of worsening prognosis
- There is “always something we can do to care for you, but we are not able to cure you”
- *not in order of prevalence*

LaPOST
Louisiana Physician Orders for Scope of Treatment
A Participating Program of National POLST

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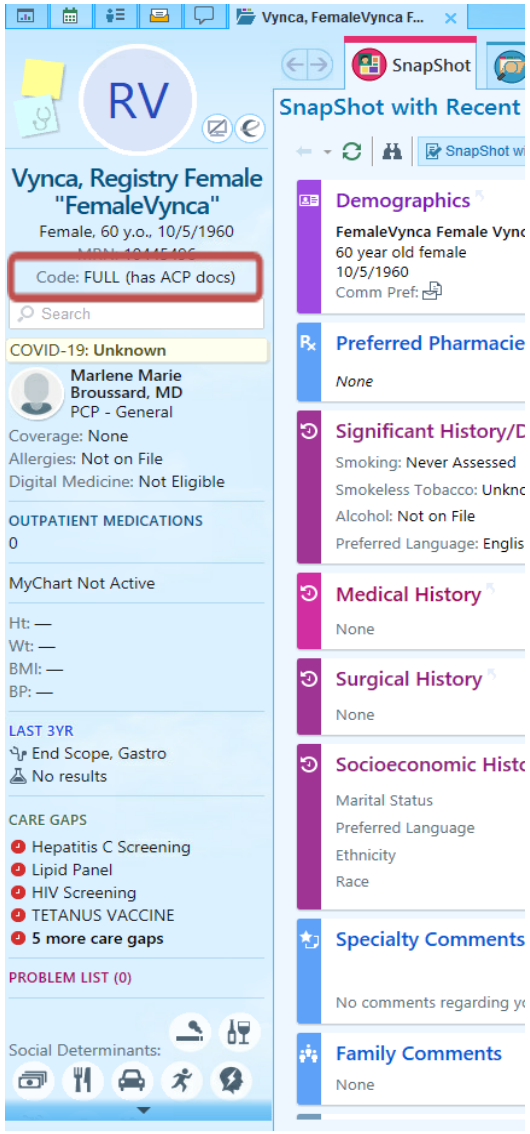
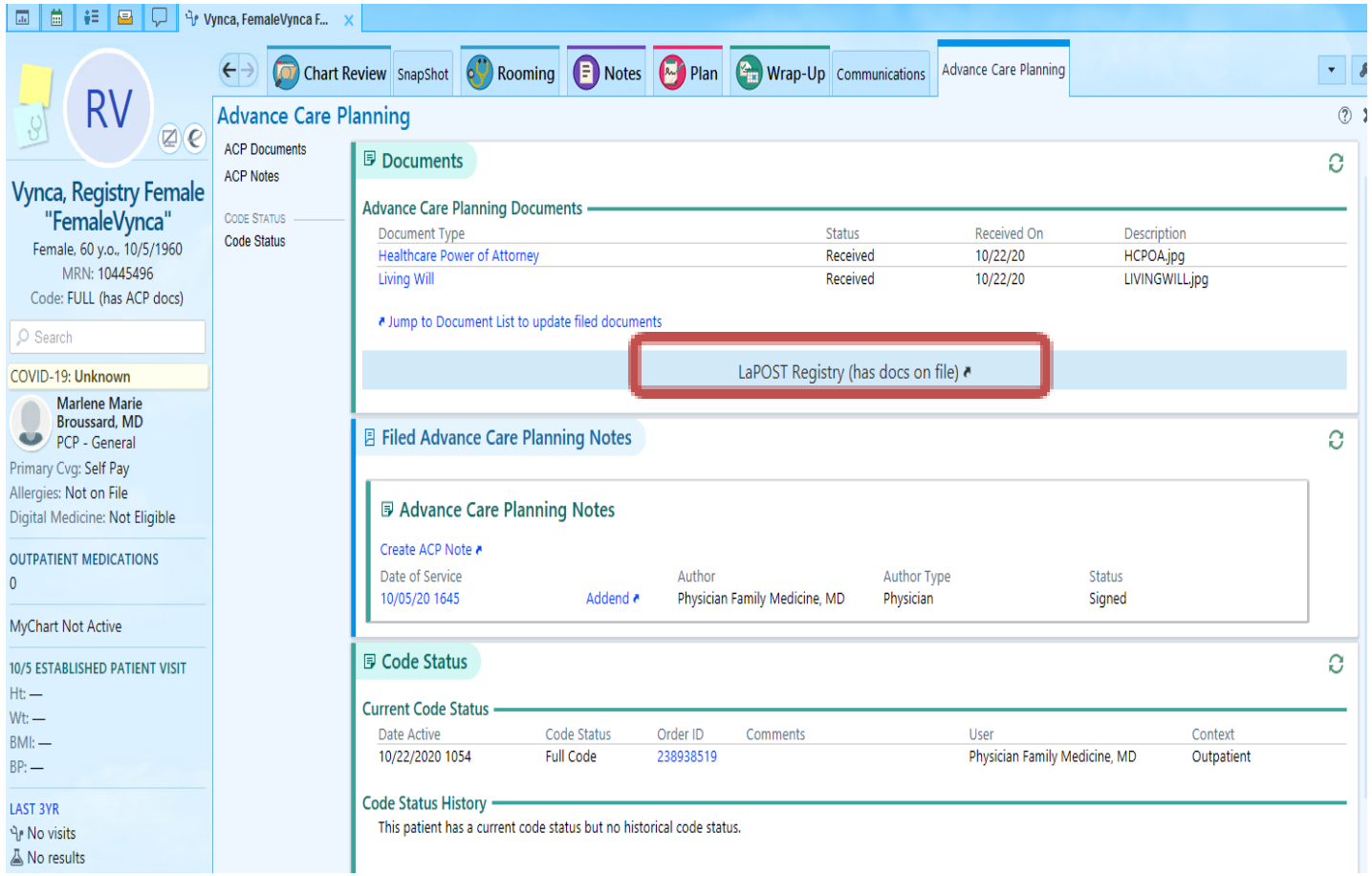
Epic Integration- Advance Care Planning Activity from the Code status Bar





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LaPOST

Louisiana Physician Orders for Scope of Treatment

A Participating Program of National POLST

- **A process**.
  - Part of advance care planning, which helps you live the best life possible.
- **Conversations**.
  - A good talk with your provider about your medical condition, treatment options, and what you want.
- **A portable medical order form** that travels with you (called a POLST form www.polst.org).

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LaPOST

- Voluntary
- ONLY for those with serious advanced illness or frailty
- NOT VALID unless signed by the patient (decision maker) and MD/DO or others depending on state law
- NOT just a check box form but the result of conversations between the patient, their family and the appropriate health care professional
- Complementary with advance directives
- Revised with changes in the patient condition
- Changed or voided by the patient at any time based on their wishes
- Louisiana has an electronic registry embedded in ACP module in Ochsner EPIC

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

LOUISIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (LaPOST)

FIRST follow these orders, **THEN** contact physician. This is a Physician Order form based on the person's medical condition and preferences. Any section not completed implies full treatment for that section. LaPOST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect. Please see www.La-POST.org for information regarding "what my cultural/religious heritage tells me about end of life care."

LAST NAME

FIRST NAME/MIDDLE NAME

DATE OF BIRTH **MEDICAL RECORD NUMBER** (optional)

PATIENT'S DIAGNOSIS OF LIFE LIMITING DISEASE AND IRREVERSIBLE CONDITION:

GOALS OF CARE:

A. CARDIOPULMONARY RESUSCITATION (CPR): PERSON IS UNRESPONSIVE, PULSELESS AND IS NOT BREATHING

CHECK ONE
- ☐ CPR/Attempt Resuscitation (requires full treatment in section B)
- ☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B. MEDICAL INTERVENTIONS: PERSON HAS PULSE OR IS BREATHING

CHECK ONE
- ☐ FULL TREATMENT (primary goal of prolonging life by all medically effective means) Use treatments in Selective Treatment and Comfort Focused treatment. Use mechanical ventilation, advanced airway interventions and cardioversion if indicated.
- ☐ SELECTIVE TREATMENT (primary goal of treating medical conditions while avoiding burdensome treatments) Use treatments in Comfort Focused treatment. Use medical treatment, including antibiotics and IV fluids as indicated. May use non invasive positive airway pressure (CPAP/BiPAP). Do not intubate. Generally avoid intensive care.
- ☐ COMFORT FOCUSED TREATMENT (primary goal is maximizing comfort) Use medication by any route to provide pain and symptom management. Use oxygen, suctioning and manual treatment of airway obstruction as needed to relieve symptoms. (Do not use treatments listed in full or selective treatment unless consistent with goals of care. Transfer to hospital ONLY if comfort focused treatment cannot be provided in current setting.)

ADDITIONAL ORDERS: (e.g. dialysis, etc.)

Medically assisted nutrition and hydration is optional when it
- cannot reasonably be expected to prolong life
- would be more burdensome than beneficial
- would cause significant physical discomfort

C. ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: (Always offer food/fluids by mouth as tolerated)

CHECK ONE
- ☐ No artificial nutrition by tube.
- ☐ Trial period of artificial nutrition by tube. (Goal: _____)
- ☐ Long-term artificial nutrition by tube. (If needed)

D. SUMMARY

Discussed with: ☐ Patient (Patient has capacity) ☐ Personal Health Care Representative (PHCR)

The basis for these orders is:

CHECK ALL THAT APPLY
- ☐ Patient's declaration (can be oral or nonverbal)
- ☐ Patient's Personal Health Care Representative (Qualified Patient without capacity)
- ☐ Patient's Advance Directive, if indicated, patient has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity.
- ☐ Resuscitation would be medically non-beneficial.
- ☐ Advance Directive dated _____, available and reviewed
- ☐ Advance Directive not available
- ☐ No Advance Directive
- ☐ Health care agent if named in Advance Directive:

Name: _____

Phone: _____

This form is voluntary and the signatures below indicate that the physician orders are consistent with the patient's medical condition and treatment plan and are the known desires or in the best interest of the patient who is the subject of the document.

PRINT PHYSICIAN'S NAME | PHYSICIAN SIGNATURE (MANDATORY) | PHYSICIAN PHONE NUMBER | DATE (MANDATORY)

PRINT PATIENT OR PHCR NAME | PATIENT OR PHCR SIGNATURE (MANDATORY) | DATE (MANDATORY)

PHCR RELATIONSHIP | PHCR ADDRESS | PHCR PHONE NUMBER

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

USE OF ORIGINAL FORM IS STRONGLY ENCOURAGED. PHOTOCOPIES AND FAXES OF SIGNED LaPOST FORMS ARE LEGAL AND VALID.

V2.06.13.2016

LAST NAME **FIRST NAME** **MIDDLE NAME** **DATE OF BIRTH**

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

COMPLETING LaPOST

- Must be completed by a physician and patient or their personal health care representative based on the patient's medical conditions and preferences for treatment.
- **LaPOST** must be signed by a physician and the patient or PHCR to be valid. Verbal orders are acceptable from physician and verbal consent may be obtained from patient or PHCR according to facility/community policy.
- Use of the brightly colored original form is strongly encouraged. Photocopies and faxes of signed **LaPOST** are legal and valid.

USING LaPOST

- Completing a **LaPOST** form is voluntary. Louisiana law requires that a **LaPOST** form be followed by health care providers and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- **LaPOST** does not replace the advance directive. When available, review the advance directive and **LaPOST** form to ensure consistency and update forms appropriately to resolve any conflicts.
- The personal health care representative includes persons described who may consent to surgical or medical treatment under RS 40:1159.4 and may execute the **LaPOST** form only if the patient lacks capacity.
- If the form is translated, it must be attached to a signed **LaPOST** form in ENGLISH.
- Any section of **LaPOST** not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation".
- Medically assisted nutrition and hydration is optional when it cannot reasonably be expected to prolong life, would be more burdensome than beneficial or would cause significant physical discomfort.
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort focused treatment," should be transferred to a setting able to provide comfort (e.g. pinning of a hip fracture).
- A person who chooses either "Selective treatment" or "Comfort focused treatment" should not be entered into a Level I trauma system.
- Parenteral (IV/Subcutaneous) medication to enhance comfort may be appropriate for a person who has chosen "Comfort focused treatment."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective treatment" or "Full treatment."
- A person with capacity or the personal representative (if the patient lacks capacity) can revoke the **LaPOST** at any time and request alternative treatment based on the known desires of the individual or, if unknown, the individual's best interests.
- Please see links on www.La-POST.org for "what my cultural/religious heritage tells me about end of life care."

The duty of medicine is to care for patients even when they cannot be cured. Physicians and their patients must evaluate the use of technology available for their personal medical situation. Moral judgments about the use of technology to maintain life must reflect the inherent dignity of human life and the purpose of medical care.

REVIEWING LaPOST

This **LaPOST** should be reviewed periodically such as when the person is transferred from one care setting or care level to another, or there is a substantial change in the person's health status. A new LaPOST should be completed if the patient wishes to make a substantive change to their treatment goal (e.g. reversal of prior directive). When completing a new form, the old form must be properly voided and retained in the medical chart.

To void the **LaPOST** form, draw line through "Physician Orders" and write "VOID" in large letters. This should be signed and dated.

REVIEW OF THIS LaPOST FORM

REVIEW DATE AND TIME	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME
			☐ No Change ☐ Form Voided and New Form Completed
			☐ No Change ☐ Form Voided and New Form Completed
			☐ No Change ☐ Form Voided and New Form Completed
			☐ No Change ☐ Form Voided and New Form Completed
			☐ No Change ☐ Form Voided and New Form Completed
			☐ No Change ☐ Form Voided and New Form Completed

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

USE OF ORIGINAL FORM IS STRONGLY ENCOURAGED. PHOTOCOPIES AND FAXES OF SIGNED LaPOST FORMS ARE LEGAL AND VALID.

V2.06.13.2016

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Mississippi documents (can be found on Sharepoint)

INSTRUCTIONS

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT

MISSISSIPPI ADVANCE HEALTH CARE DIRECTIVE - PAGE 2 OF 8

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____
(Name of individual you choose as agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____
(Name of individual you choose as first alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a healthcare decision for me, I designate as my second alternate agent:

_____
(Name of individual you choose as second alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

MISSISSIPPI PHYSICIAN ORDERS FOR SUSTAINING TREATMENT (POST)

- This document is based on this person's current medical condition and wishes and is to be reviewed for potential replacement in the case of a substantial change in either
- HIPAA permits disclosure of POST to other health professionals as necessary
- Any section not completed indicates preference for full treatment for that section

Patient Last Name	Patient First Name/Middle
Patient Date of Birth	Effective Date (Form must be reviewed at least annually)

A (Check one)
CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing.
☐ Attempt Resuscitation (CPR)
☐ Do Not Attempt Resuscitation (DNR)
*When not in cardiopulmonary arrest, follow orders in **B**, **C**, and **D**.*

B (Check One)
MEDICAL INTERVENTIONS: If the patient has pulse AND breathing OR has pulse and is NOT breathing.
☐ **Full Sustaining Treatment:** Transfer to a hospital if indicated. Includes intensive care. Treatment Plan: Full treatment including life support measures. Provide treatment including the use of intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardioversion as indicated, medical treatment, intravenous fluids, and comfort measures.
☐ **Limited Interventions:** Transfer to a hospital if indicated. Avoid intensive care. Treatment Plan: Provide basic medical treatments. In addition to care described in Comfort Measures below, provide the use of medical treatment; oral and intravenous medications; intravenous fluids; cardiac monitoring as indicated; noninvasive bi-level positive airway pressure; a bag valve mask. This option excludes the use of intubation or mechanical ventilation.
ADDITIONAL ORDERS: (e.g., vasopressors, dialysis, etc.)_____
☐ **Comfort Measures Only**: Treatment Goal: Maximize comfort through use of medication by any route; keeping the patient clean, warm, and dry; positioning, wound care, and other measures to relieve pain and suffering; and the use of oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to a hospital unless comfort needs cannot be met in the patient's current location (e.g., hip fracture).
Other instructions:_____

C (Check One)
ANTIBIOTICS:
☐ Use antibiotics if life can be sustained
☐ Determine use or limitation of antibiotics when infection occurs
☐ Use antibiotics only to relieve pain and discomfort
Other Instructions_____

D (Check One in Each of the 3 Categories)
MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Administer oral fluids and nutrition if physically possible.
Directing the administration of nutrition into blood vessels if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following:
☐ Total parenteral nutrition, long-term if indicated.
☐ Total parenteral nutrition for a defined trial period. Goal: _____
☐ No parenteral nutrition.

Directing the administration of nutrition by feeding tube if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following:
☐ Long-term feeding tube if indicated
☐ Feeding tube for a defined trial period. Goal: _____
☐ No feeding tube
OTHER INSTRUCTIONS _____

Directing the administration of hydration if physically feasible as determined in accordance with reasonable medical judgment by selecting one (1) of the following
☐ Long-term intravenous fluids if indicated
☐ Intravenous fluids for a defined trial period. Goal: _____
☐ Intravenous fluids only to relieve pain and discomfort

E (Check All That Apply)
PATIENT PREFERENCES AS A BASIS FOR THIS POST FORM (*THIS SECTION TO BE FILLED OUT WITH PATIENT DIRECTION*)
☐ Patient has an advance healthcare directive (per statute § 41-41-203): ☐ YES , Date of Execution: _____
I certify that the Physician Order for Sustaining Treatment is in accordance with the advance directive.

Signature:_____ Print Name:_____ Relationship:_____
☐ Patient is an unemancipated minor, direction was provided by the following in accordance with §41-41-3, Mississippi Code of 1972:
☐ Minor's guardian or custodian

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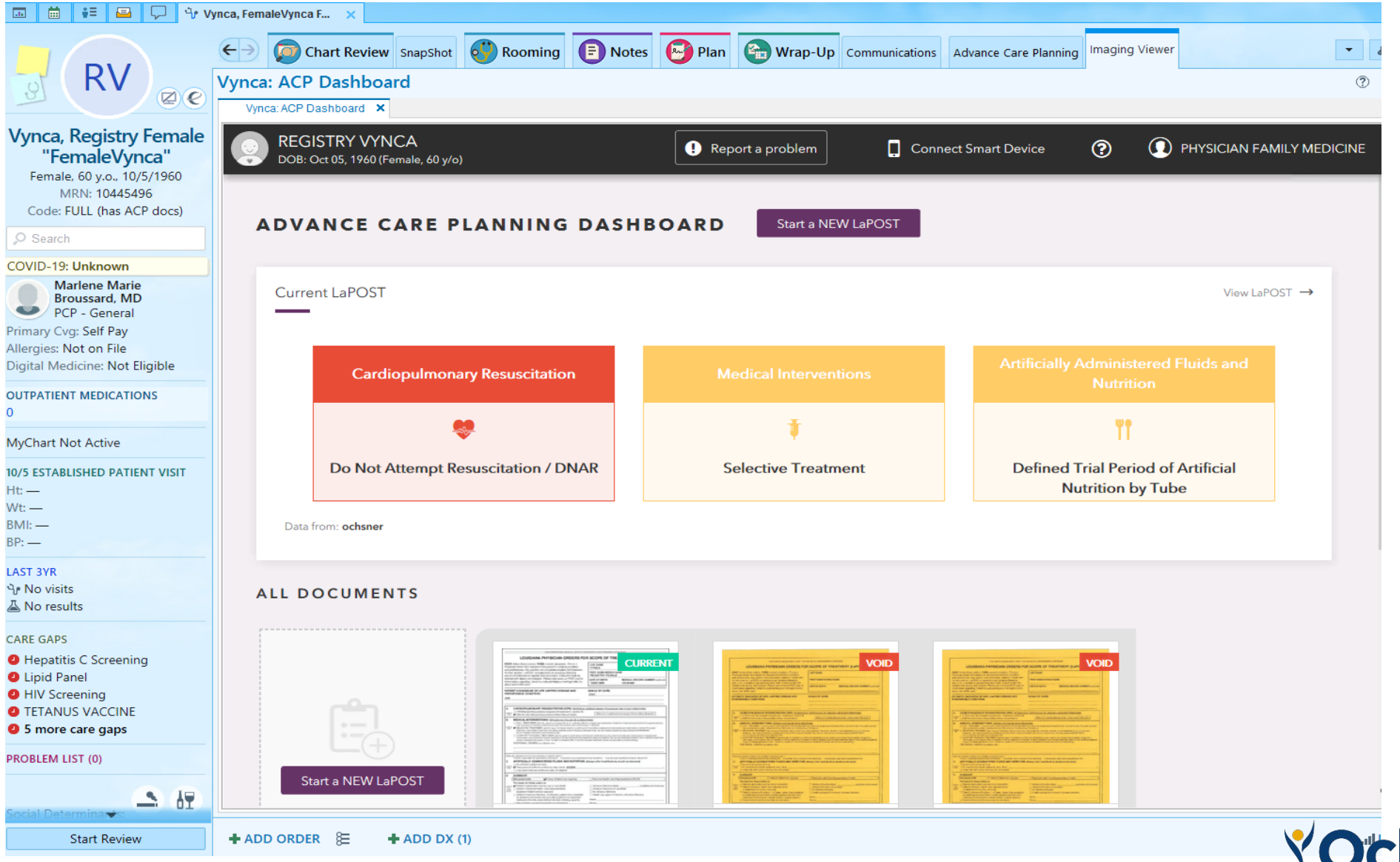
LaPOST Registry



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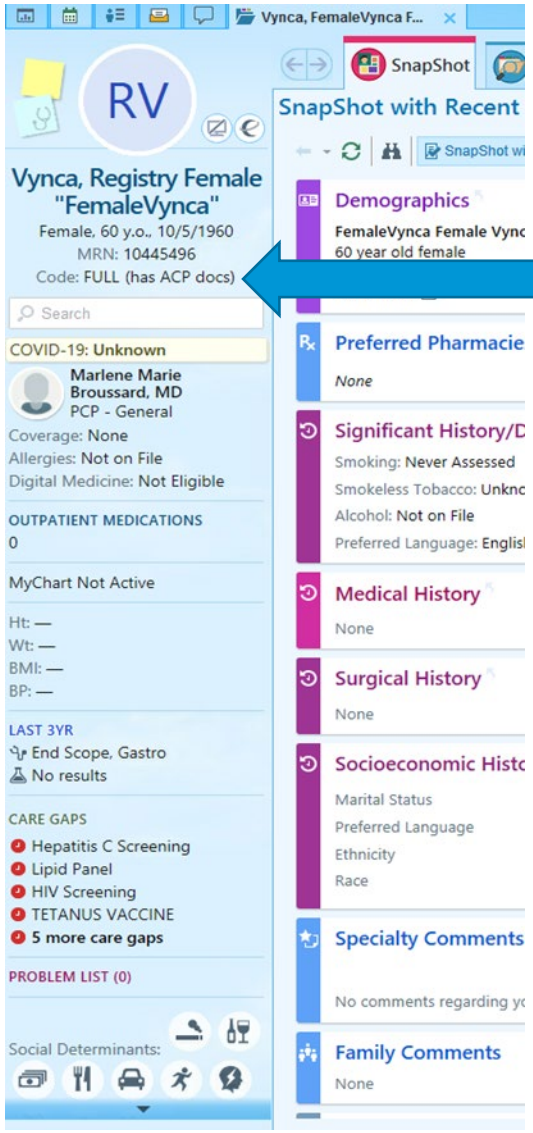
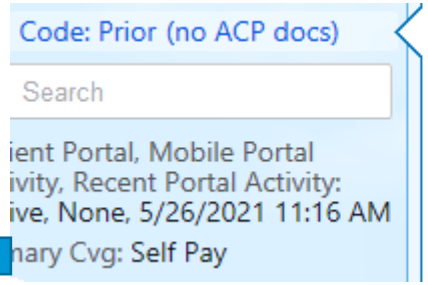
Code Status bar





Current Code Status

Prior

Code Status History

Date Active	Date Inactive	Code Status	Order ID	Comn
5/18/2021 0624	5/18/2021 1337	Full Code	638270191	

Advance Care Planning Documents

There are no Advance Care Planning documents on file.

Jump to Document List to update filed documents

LaPOST Registry (no docs on file)

Filed Advance Care Planning Notes

Advance Care Planning Notes

Create ACP Note

Date of Service		Author	Author Type	Status
05/25/21 1227	Addend	Stacey S Perrault, NP	Nurse Practitioner	Signed
05/24/21 1722	Addend	Susan E. Nelson, MD	Physician	Signed
05/24/21 1706	Edit	Susan E. Nelson, MD	Physician	Edited

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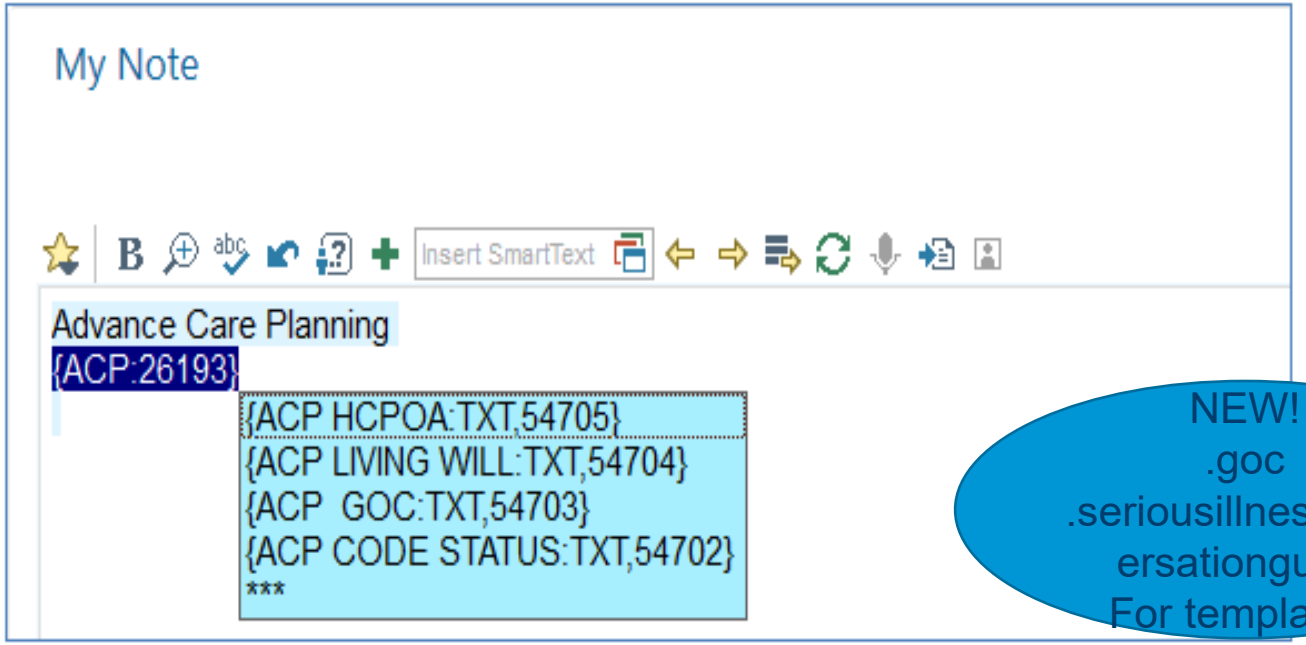
.ACP Smart Phrase

You can view any ACP note by selecting the blue hyperlink under the Date of Service. You may also select 'Edit' in order to make changes to documentation.

The '.ACP' SmartPhrase should be used within visit notes to document discussions you have with patients regarding Healthcare Power of Attorney, Living Will, Goals of Care, & Code Status. The information documented within this SmartPhrase will display in the ACP Notes section of the ACP activity.



Using **.acpbegin to** write a narrative note then bookend with **.acpend is NOT able to be captured in metrics**

NEW! .goc .seriousillnessconversationguide For templates!

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ACP conversation template

Today a meeting took place:{ACP Meeting Location:28172}

Patient Participation:{ACP Patient Participation:28173}

Attendees (Name and Relationship to patient):{ACP Attendees:28174}

Staff attendees (Name and Role): ***

ACP Conversation (General):{ACP Conversation:28175} ***

ACP Documents:{ACP Documents:28176}

Goals of care: The {ACP PT FAMLIY POA:28143} endorses that what is most important right now is to focus on {ACPPTFOUCS:26175}

Accordingly, we have decided that the best plan to meet t {ACPPTFOUCS2:26189}

Recommendations/ Follow-up tasks:{ACP Recommendations/Plans:28177}

Length of ACP conversation in minutes:{Enter in number of minutes:28

- spending time at home
- avoiding the hospital
- remaining as independent as possible
- symptom/pain control
- quality of life, even if it means sacrificing a little time
- extending life as long as possible, even it it means sacrificing quality
- curative/life-prolongation (regardless of treatment burdens)
- improvement in condition but with limits to invasive therapies
- comfort and QOL
- ***

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Do you get paid for Advance Care Planning? YES

- 99497 advance care planning including the explanation and discussion of advance directives such as standard forms with and without completion of the forms by a MD/DO/NP/PA; first 30 minutes, face to face with the patient, family member(s) and/or surrogate.
- 99498 each additional 30 minutes
  - Can be used daily if necessary!
- They can also be used in addition to E/M coding with the following stipulation:
  - The 99497 code can only be used after 16 minutes has elapsed after the E/M code (16-45 minutes)
  - The 99498 code is used from 46-75 minutes additional time.
- Documentation may include:
    - The physician evaluates the patient's capacity to understand the risks, benefits, and alternatives to specific treatment
    - The physician elicits patient's values and goals for treatment
    - The physician may explain and review advance directives and LaPOST (MS MOST), if appropriate, with or without completion of documents
    - The patient is given an opportunity to review a blank advance directive or LaPOST (MS MOST) if appropriate.

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WHY MSQ (mandatory surprise question)?

Would you be surprised if this patient died in the next 6 months?
If no, there are options in EPIC to complete!

- Helps to create a standard of care our patients/families want
- Provides equitable access
- Ensures all patients with serious illness have access to quality discussions about **goals of care** and **end of life preferences**
- “Right care for the right patients at the right time in the right place”

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Why is all of this so important?
Mandatory Surprise Question and BPCI Advanced

Ochsner is participating in the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model

ACP CPT (billable)/CPT II (nonbillable tracking) codes are the markers of ACP conversations for the purposes of BPCI Advanced

ACP conversations are a quality metric for BPCI Advanced

The ACP note within the MSQ workflow will automatically produce the ACP CPT II code

MSQ will drive improved performance in BPCI Advanced

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IHI Age Friendly Health Systems

- https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Age_Friendly_What_Matters_to_Older_Adults_Toolkit.pdf

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Literature Review

- Practical guidance for ICU family meetings
- Chest 2008

VALUE: 5-step Approach to Improving Communication in ICU with Families

- V… Value family statements
- A… Acknowledge family emotions
- L… Listen to the family
- U… Understand the patient as a person
- E… Elicit family questions

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Literature review:

- Prior GeriPal podcast with Randy Curtis on an earlier study of the JumpStart patient-priming intervention for goals of care discussion
- **Conclusions:**
- Sending patients a priming questionnaire led to improved communication and discussions about goals of care.
- ICU family meetings: Increased proportion of family speech is associated with increased satisfaction
- **Conclusions:**
- This study suggests that allowing family members more opportunity to speak during conferences may improve family satisfaction. Future studies should assess the effect of interventions to increase listening by critical care clinicians on the quality of communication and the family experience.
- Alterations in translated ICU family meetings
- **Conclusions:**
- Alterations in medical interpretation seem to occur frequently and often have the potential for negative consequences on the common goals of the family conference. Further studies examining and addressing these alterations may help clinicians and interpreters to improve communication with family members during ICU family conferences.
- A communication strategy and brochure for ICU family meetings
- **CONCLUSIONS:**
- Providing relatives of patients who are dying in the ICU with a brochure on bereavement and using a proactive communication strategy that includes longer conferences and more time for family members to talk may lessen the burden of bereavement.

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Literature Review

- Practical guidance for ICU family meetings
- Chest 2008
- Curtis JR, White DB. Practical guidance for evidence-based ICU family conferences. *Chest*. 2008;134(4):835-843. doi:10.1378/chest.08-0235

Table 2—*Additional Communication Components Shown to be Associated With Increased Quality of Care, Decreased Family Psychological Symptoms, or Improved Family Ratings of Communication*

Conduct family conference within 72 h of ICU admission[38,39]
Identify a private place for communication with family members[16]
Provide consistent communication from different team members[16]
Increase proportion of time spent listening to family rather than talking[41]
Empathic statements[43]
Statements about the difficulty of having a critically ill loved one
Statements about the difficulty of surrogate decision making
Statements about the impending loss of a loved one
Identify commonly missed opportunities[36]
Listen and respond to family members
Acknowledge and address family emotions
Explore and focus on patient values and treatment preferences
Explain the principle of surrogate decision making to the family (the goal of surrogate decision making is to determine what the patient would want if the patient were able to participate)
Affirm nonabandonment of patient and family[44]
Assure family that the patient will not suffer[42]
Provide explicit support for decisions made by the family[42]

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Literature Review

- Empathy in life support decisions

- **Conclusions:** Physicians vary considerably in the extent to which they express empathy to surrogates during deliberations about life support, with no empathic statements in one-third of conferences. There is an association between more empathic statements and higher family satisfaction with communication.

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Ariadne Labs/Serious Illness Conversation Program

SERIOUS ILLNESS CARE PROGRAM - Ariadne Labs

- Clinicians:
  - Positive experiences for clinicians
  - 90% found the Serious Illness Conversation Guide effective and efficient to use.
  - 70% reported more satisfaction in their role.
  - ⅔ experienced less anxiety in having these conversations.
- Systems:
  - While data from a randomized trial in advanced cancer showed no changes in healthcare utilization, evidence from a pragmatic trial in a primary care high risk care management program demonstrated changes in care delivery and costs at the end of life.
  - $2,579 PMPM lower total medical expenses in the last 6 months of life ($4,143 in the last 3 months) for patients who had conversations compared to those who did not.
  - Decedents in program-implementing clinics had 3x higher rates of hospice enrollment for > 30 days.

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Literature Review

Bernacki, R. E., Block, S. D., & American College of Physicians High Value Care Task Force. (2014). Communication about serious illness care goals: a review and synthesis of best practices. *JAMA Internal Medicine, 174*(12), 1994–2003. https://doi.org/10.1001/jamainternmed.2014.5271

Lakin, J. R., et al. (2016, July 11). Improving Communication about serious illness in primary care: A review. *JAMA InternMed. 176(9)*. 1380-1387. https://doi.org/10.1001/jamainternmed.2016.3212

Yahanda, A. T., & Mozersky, J. (2020). What's the role of time in shared decision making? *AMA Journal of Ethics*, *22*(5), E416–422. https://doi.org/10.1001/amajethics.2020.416

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