UPDATE on Palliative Care

Susan E. Nelson, MD, FACP, FAAHPM
System Chair, Palliative Medicine and Supportive Care
System Chair, Bioethics
Ochsner Health
November 11, 2021

Ochsner Health

Disclosures

- NONE

Learning Objectives

- At the completion of this regularly scheduled activity, participants should be able to:
  - *Update on what palliative medicine and supportive care is…..*
  - *Review of the ASCO recommendations*
  - *Discussion of why advance care planning conversations are essential to "provide the best care possible"*

What is Palliative Medicine and Supportive Care?

- Palliative Care is an "**extra layer of support for people with serious illness and their families**".
- Priorities include:
  - Pain and symptom management regardless of types of treatment received
  - Navigating the health care system
  - Having conversations about the types of care desired so that the care received matches what is desired and DOCUMENTING that in the Advance Care Planning module
    - Documentation completed using templated phrases allows everyone access to this information. (ACP module on EPIC)

Palliative Medicine and Supportive Care

Outpatient clinic, telehealth and home visits-Ochsner Care @Home

ASCO Clinical Practice Guidelines

DOI: 10.1200/EDBK_175474 *American Society of Clinical Oncology Educational Book* 37 (October 29, 2018) 714-723.

- Using the New ASCO Clinical Practice Guideline for Palliative Care Concurrent With Oncology Care Using the TEAM Approach | American Society of Clinical Oncology Educational Book (ascopubs.org)
- Guideline Question Should palliative care concurrent with oncology care be standard practice?
- Answer: Yes, unequivocally. And EARLY, within 8 weeks, not at the end of life.
- Key Recommendation
  - Patients with advanced cancer, inpatient and outpatient, should receive dedicated palliative care services early in the disease course, concurrent with active treatment.
  - Referring patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs.
  - Providers may refer caregivers of patients with early or advanced cancer to palliative care services

Specific Recommendations

- Patients with advanced cancer should be referred to interdisciplinary palliative care teams (consultation) that provide inpatient and outpatient care early in the course of disease, alongside active treatment of their cancer.
(Type: evidence based, benefit outweighs harms; Evidence quality: intermediate; Strength of recommendation: strong).
- Palliative care for patients with advanced cancer should be delivered through interdisciplinary palliative care teams with consultation available in both outpatient and inpatient settings (Type: evidence based, benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).

Specific Recommendations

- Patients with advanced cancer should receive palliative care services, which may include a referral to a palliative care provider.
- Essential components of palliative care include may include:
  - rapport and relationship building with patient and family caregiver(s)
  - symptom, distress, and functional status management (i.e., pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation)
  - exploration of understanding and education about illness and prognosis
  - clarification of treatment goals
  - assessment and support of coping needs (i.e., provision of dignity therapy)
  - assistance with medical decision making
  - coordination with other care providers
  - provision of referrals to other care providers as indicated.

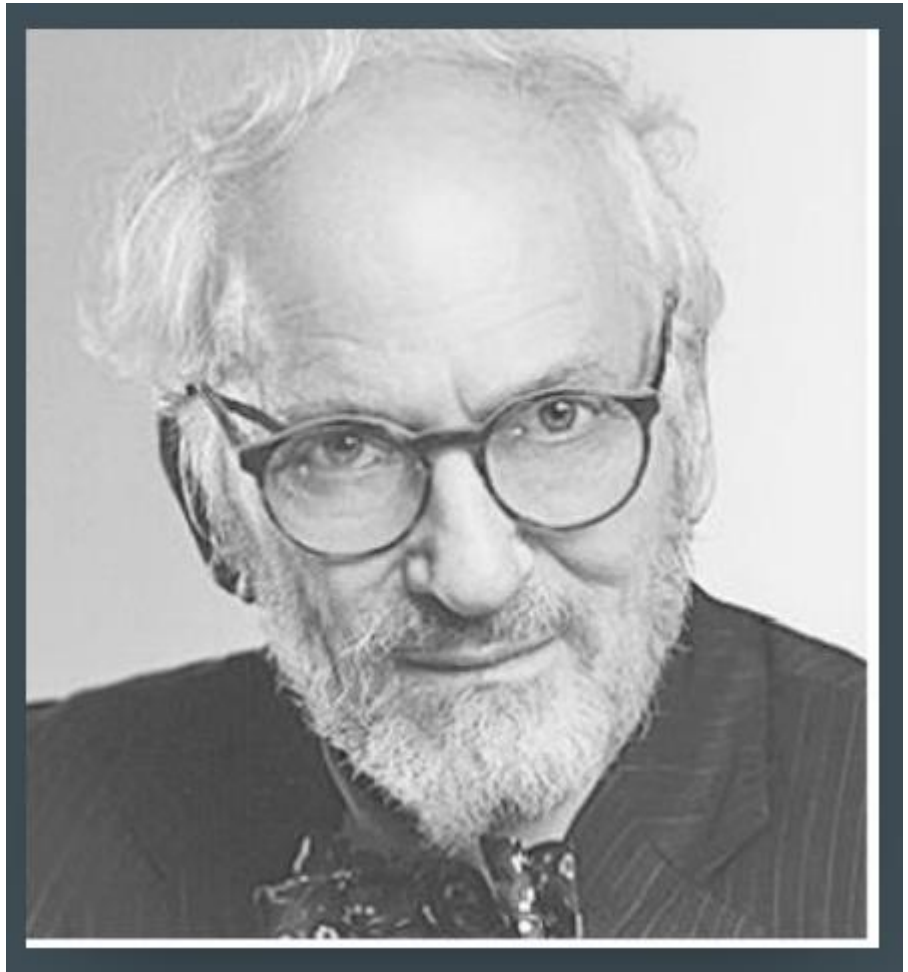
Specific Recommendations

- For newly diagnosed patients early palliative care involvement, within 8 weeks of diagnosis, is suggested. (Type: informal consensus, Evidence quality: intermediate; Strength of recommendation: moderate).
- Among patients with cancer with high symptom burden, high expectant needs, or great anticipation of experiencing overlapping phases of care, (diagnosis, staging, treatment, and end of life), outpatient programs of cancer care should provide and use dedicated resources (palliative care clinicians) to deliver palliative care services to complement existing program tools (Type: evidence-based, benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).
- For patients with early or advanced cancer for whom family caregivers will provide care in the outpatient setting, nurses, social workers, or other providers may initiate caregiver-tailored palliative care support, which could include telephone coaching, education, referrals, and face-to-face meetings. For family caregivers who may live in rural areas or be unable to travel to clinic, offering telephone support over face-to-face support may be offered (Type: evidence-based; Evidence quality: low; Strength of recommendation: Weak)

- His work focused on the nature of suffering and that it "threatens the intactness of the person as a complex social and psychological entity."
- Healthcare providers who fail to "understand the nature of suffering can result in medical intervention that... not only fails to relieve suffering but becomes a source of suffering itself. "(N Engl J Med. 1982; 306:639–45.)

ERIC CASSELL MD MACP

- Died 9/24/2021 at age 93



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

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-many opportunities for learning!
- 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!
- Confusion about who should initiate the discussion-EVERYONE should own this!
- Lack of systems to implement conversations and ensure quality and control-learn a structured conversation technique and stick with it!
- Shortage of palliative care specialists

Think of conversations as procedures….

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

Ochsner

We are working to *change the culture* at Ochsner

Out with the old

- **Identify all options and then ask patient what treatment decisions are**

In with the new

- **Get to know what is important to the patient, then align those goals and values with treatment decisions**

Ochsner Health

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

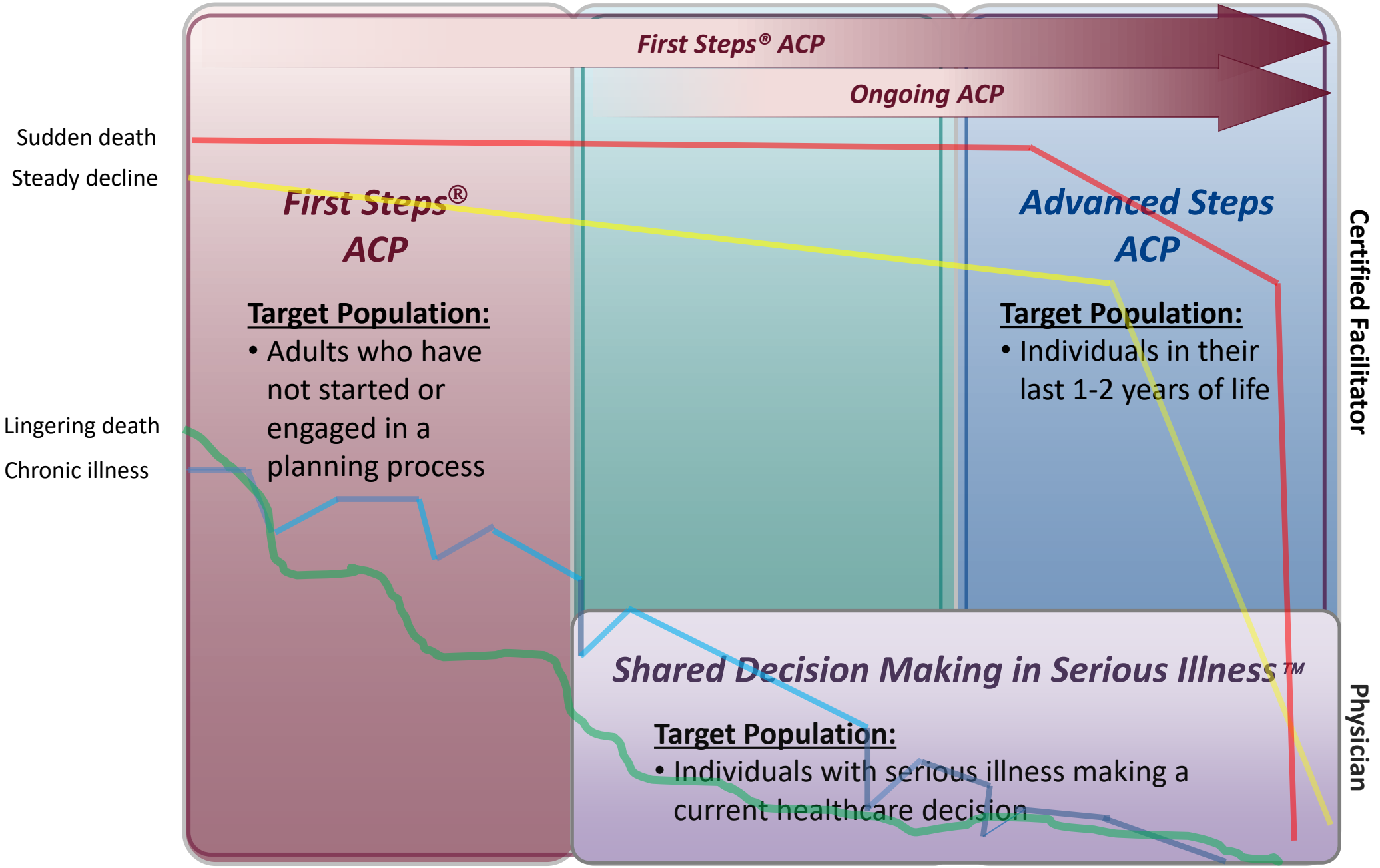
Shared Decision Making: The Need For Patient–Clinician Conversation, Not Just Information

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.***

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

Stages of Person-Centered Decision Making and Disease Trajectory



How did we get here????

- Karen Ann Quinlan KAREN ANN QUINLAN, 31, DIES; FOCUS OF '76 RIGHT TO DIE CASE - The New York Times (nytimes.com)
- Nancy Cruzan "Departed, Jan 11, 1983; At Peace, Dec 26, 1990" | Journal of Ethics | American Medical Association (ama-assn.org)
- A Conversation with Bill Colby about Nancy Cruzan MP3 (practicalbioethics.org)
- “The LONG GOODBYE” and “Unplugged: Reclaiming our Right to Die in America” by William Colby
- Terri Schiavo The Terri Schiavo Saga: The Making of a Tragedy and Lessons Learned - Mayo Clinic Proceedings

Decision Making Conversation Frameworks

- www.respectingchoices.org will be taught at Ochsner
- SERIOUS ILLNESS CARE - Ariadne Labs
- 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?

Advance Care Planning

- Ongoing process of developing future medical care plans
- Not a “one size fits all” discussion
- Must be individualized to patient readiness and stage of health

Power of Attorney for Health Care

OCHSNER HEALTH SYSTEM
ADVANCE DIRECTIVE

POWER OF ATTORNEY FOR
HEALTH CARE DECISIONS

The Person I Want to Make Health Care Decisions for Me When I Cannot Make Them for Myself

If I, _____, being of sound mind, am no longer able to make my own health care decisions, the person I choose as my Health Care Power of Attorney is:

First Choice Name: _____

Address: _____ Phone Number: _____

If this person is not able or willing to make these choices for me, OR is divorced or legally separated from me, OR this person has died, then these people are my next choices:

Second Choice Name: _____ **Third Choice Name:** _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Phone: _____ Phone: _____

I understand that my Health Care Power of Attorney can make health care decisions for me, including decisions concerning the withholding or withdrawal of life sustaining procedures.

Such Health Care Power of Attorney has full authority to make such decisions as fully, completely and effectually, and to all intents and purposes with the same validity as if such decisions had been personally made by me.

This Health Care Power of Attorney is effective immediately and serves to revoke and supersede any prior Health Care Power of Attorney I have previously executed. This Health Care Power of Attorney will continue until it is revoked.

Living Will

OCHSNER HEALTH SYSTEM
ADVANCE DIRECTIVE
LIVING WILL

WITHHOLDING OR WITHDRAWAL OF
LIFE SUSTAINING MEDICAL PROCEDURES
(LA.REV.STAT.40:1299.58.3)

The Kind of Medical Treatment I Want or Do Not Want

I, _____, believe that my life is precious and I deserve to be treated with dignity. If the time comes that I am very sick and am not able to speak for myself, I would like for my wishes to be respected and followed. The instructions that I am including in this section are to let my family, my doctors and other health care providers, my friends and all others know the kind of medical treatment that I want or do not want.

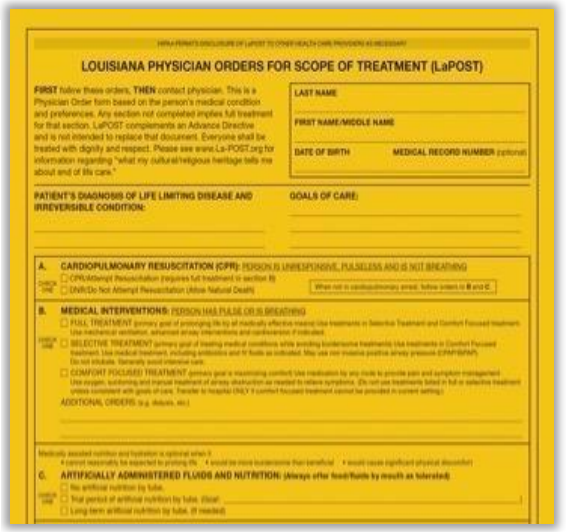
If at any time I should have an incurable injury, disease, or illness, or be in a continual, profound comatose state with no reasonable chance of recovery, certified to be in a terminal and irreversible condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to prolong artificially the dying process, I would like the following instructions to be followed.
(Choose *one* of the following):

☐ That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.
☐ That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or

LaPOST



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

B. MEDICAL INTERVENTIONS: PERSON HAS PULSE OR IS BREATHING

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

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

Order of Decision Maker in Louisiana

- Patient for themselves
- Guardian (with authority granted by the court)
- Health Care Power of Attorney
- Spouse (unless judicially separated)
- Children* (majority of the members in a class)
- Parents
- Siblings* (majority of the members in a class)
- THEN Antecedents/Descendants
- Adult Friend https://atp.ochsner.org/sites/FMC/Consent%20Forms/20647%20Acknowledgment%20of%20Adult%20Friend%20for%20Consent%20-%20SYS.pdf
- Attending physician under certain circumstances described in the law and Ochsner policy

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

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)

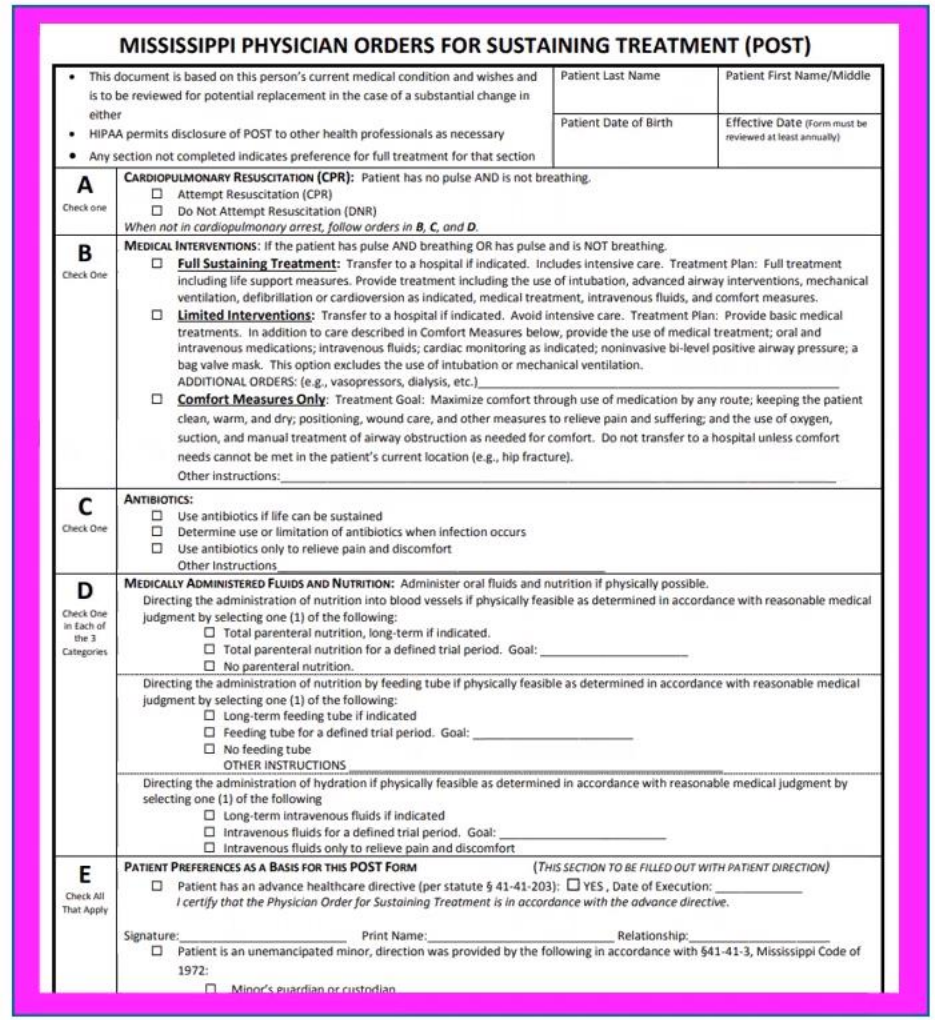
_____
(home phone) (work phone)

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

Order of Decision Maker in Mississippi

Health-Care Surrogate | Courtney Elder Law | Mississippi Elder Law (elderlawms.com)

The Surrogate must be within the designated classes of persons authorized to act as Surrogate, which are **in order of priority IF NO HCPOA document exists**:

(i) spouse, unless legally separated;
(ii) adult child;
(iii) parent;
(iv) adult brother or sister; or
(v) an adult who has exhibited special care and concern for patient, who is familiar with patient's personal values, and who is reasonably available to act.

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!**

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.

What is the evidence?

- **EFFECT OF THE SERIOUS ILLNESS CARE PROGRAM IN OUTPATIENT ONCOLOGY**
- **Conclusions:** Although the intervention did not affect the primary outcomes of goal-concordant care and peacefulness, improvements in anxiety and depression suggest that these values-based discussions can have immediate psychological benefits for patients with serious illness. The significant increase in conversations suggests that the intervention could be successfully integrated into a typical oncology practice.
- **Study Results:** *JAMA Internal Medicine*, "Effect of the Serious Illness Care Program in Outpatient Oncology: A Cluster Randomized Clinical Trial," March 2019; *JAMA Oncology*, "Evaluating an Intervention to Improve Communication Between Oncology Clinicians and Patients With Life-Limiting Cancer: A Cluster Randomized Clinical Trial of the Serious Illness Care Program," March 2019

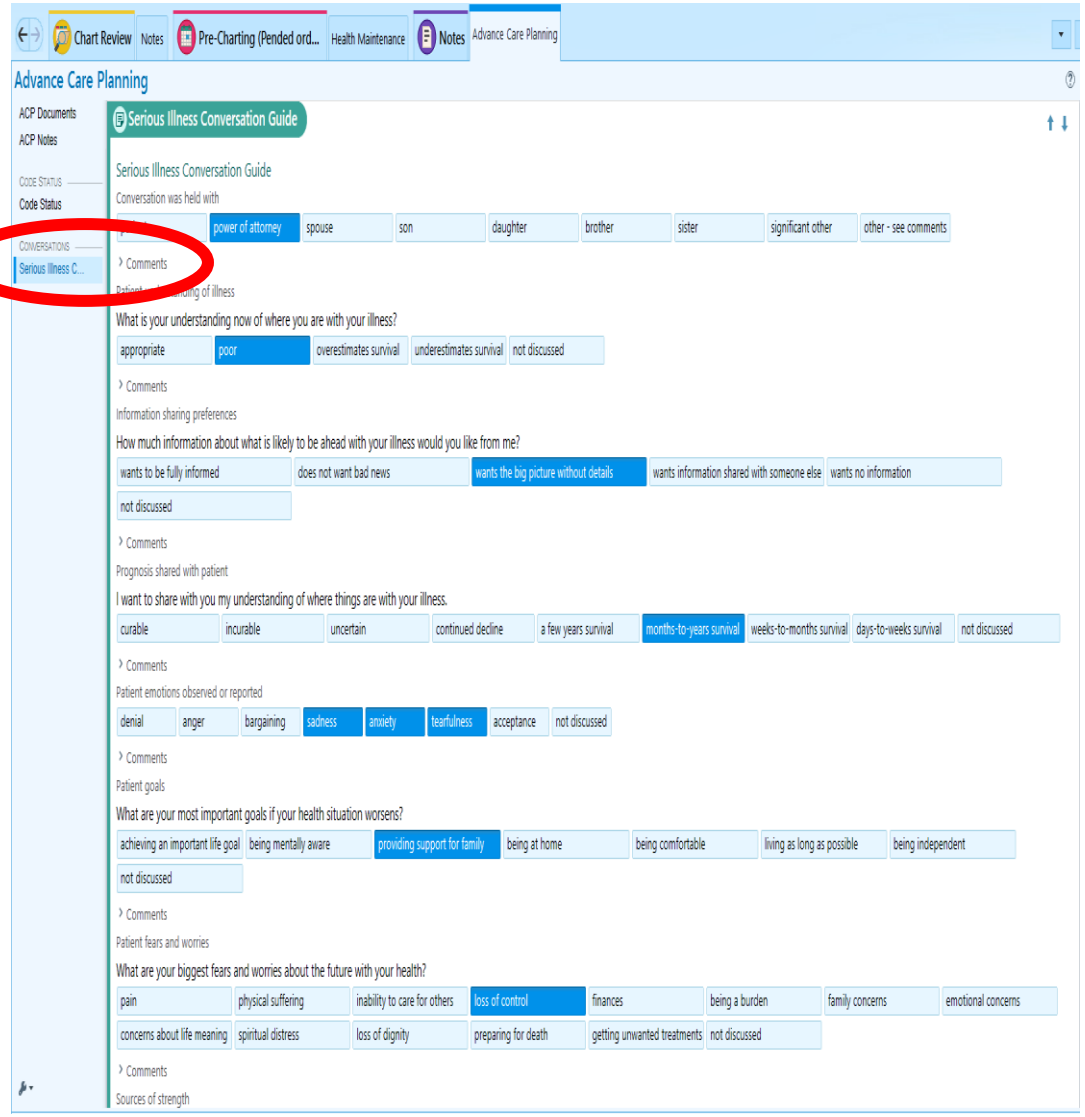
What is the evidence?

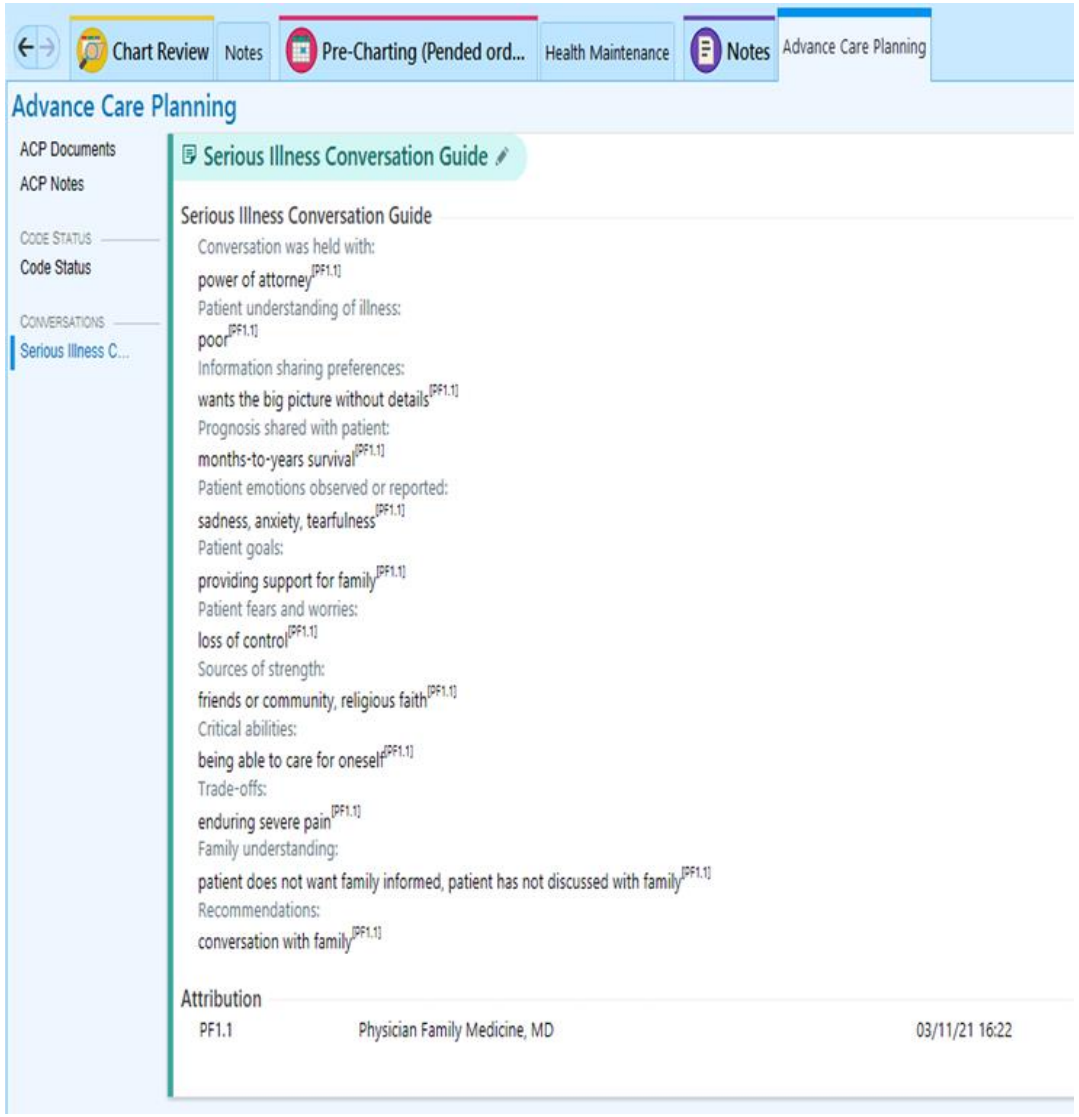
- **TESTING THE SERIOUS ILLNESS CARE PROGRAM AT THE DANA-FARBER CANCER INSTITUTE**

- **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.

Serious Illness Conversation Guide (.sicg)





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?"**
- Future work will seek to extend these findings and to gain further insight into rural and other underserved populations.

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.
-

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.

Conclusions:
Previous research has shown a culture in which African Americans do not seek out ACP and has offered potentials reasons why this might be. However, this paper shows that existing research might not accurately represent the diversity of preferences in the African American community or the experience of African Americans who are seriously ill.

To more effectively encourage ACP and engage with this community, clinicians and caregivers may need to reframe factors like religion/spirituality and family as assets.

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.

What is the evidence?

- SERIOUS ILLNESS CARE IN THE PRIMARY CARE SETTING

- **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.

What is the evidence?

- **EFFECT OF THE SERIOUS ILLNESS CARE PROGRAM ON EXPENSES AT THE END OF LIFE**

- *Healthcare*, "A systematic intervention to improve serious illness communication in primary care: Effect on expenses at the end of life," June 2020

- **Conclusions**: Programs that are designed to drive more, earlier, and better serious illness communication hold the potential to reduce costs.

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.

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.”

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?"

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."

Don’t forget…….

Document the conversation

Communicate with key clinicians

How to Start the Conversation about Advance Care Planning

Item: 56266
Revised: 06/2018

Ochsner

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

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

Ochsner Health

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

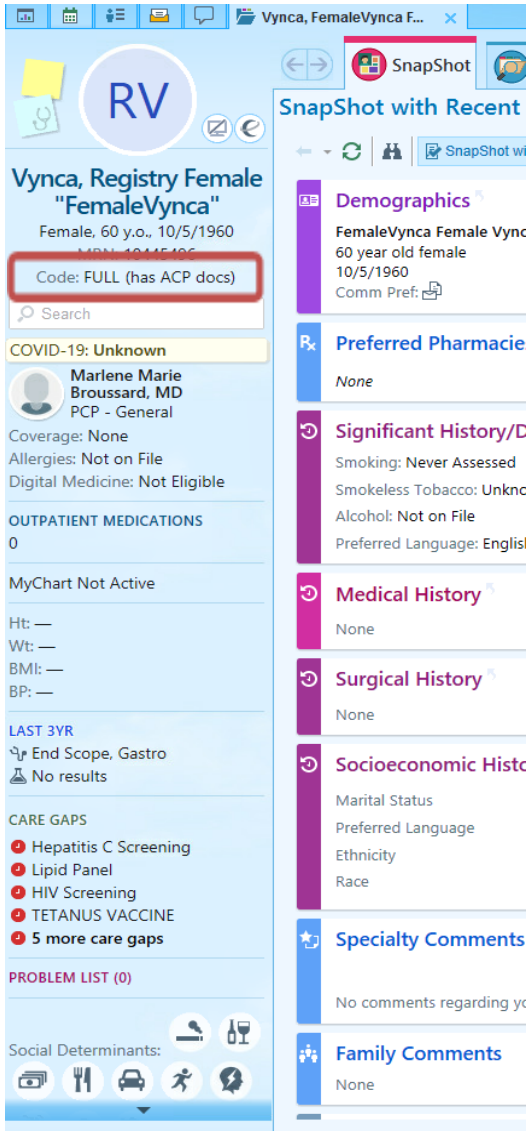
Ochsner Advance Care Planning video
https://youtu.be/wUAiTlgEVvU

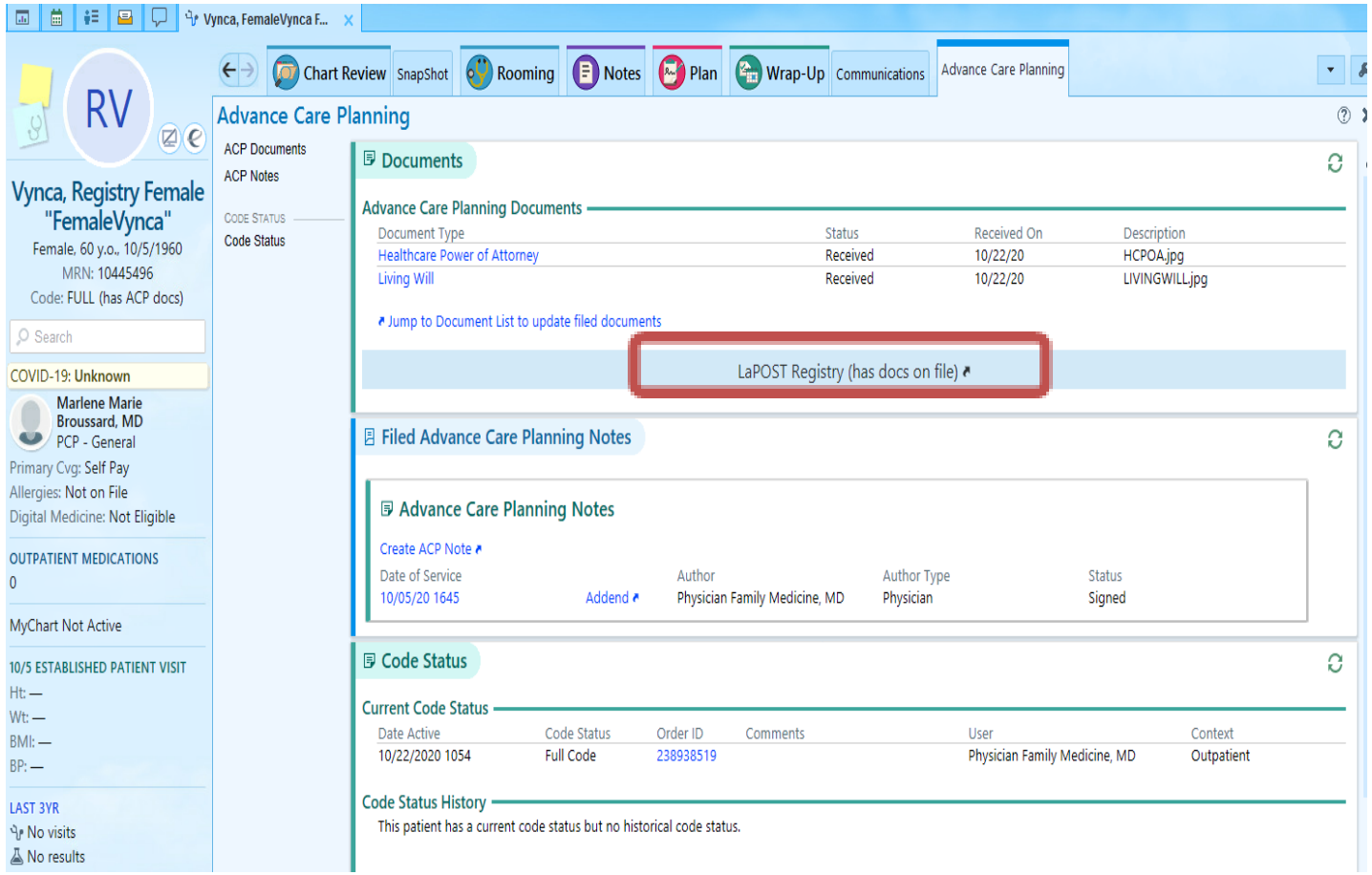
Thank you!

This is really important work!

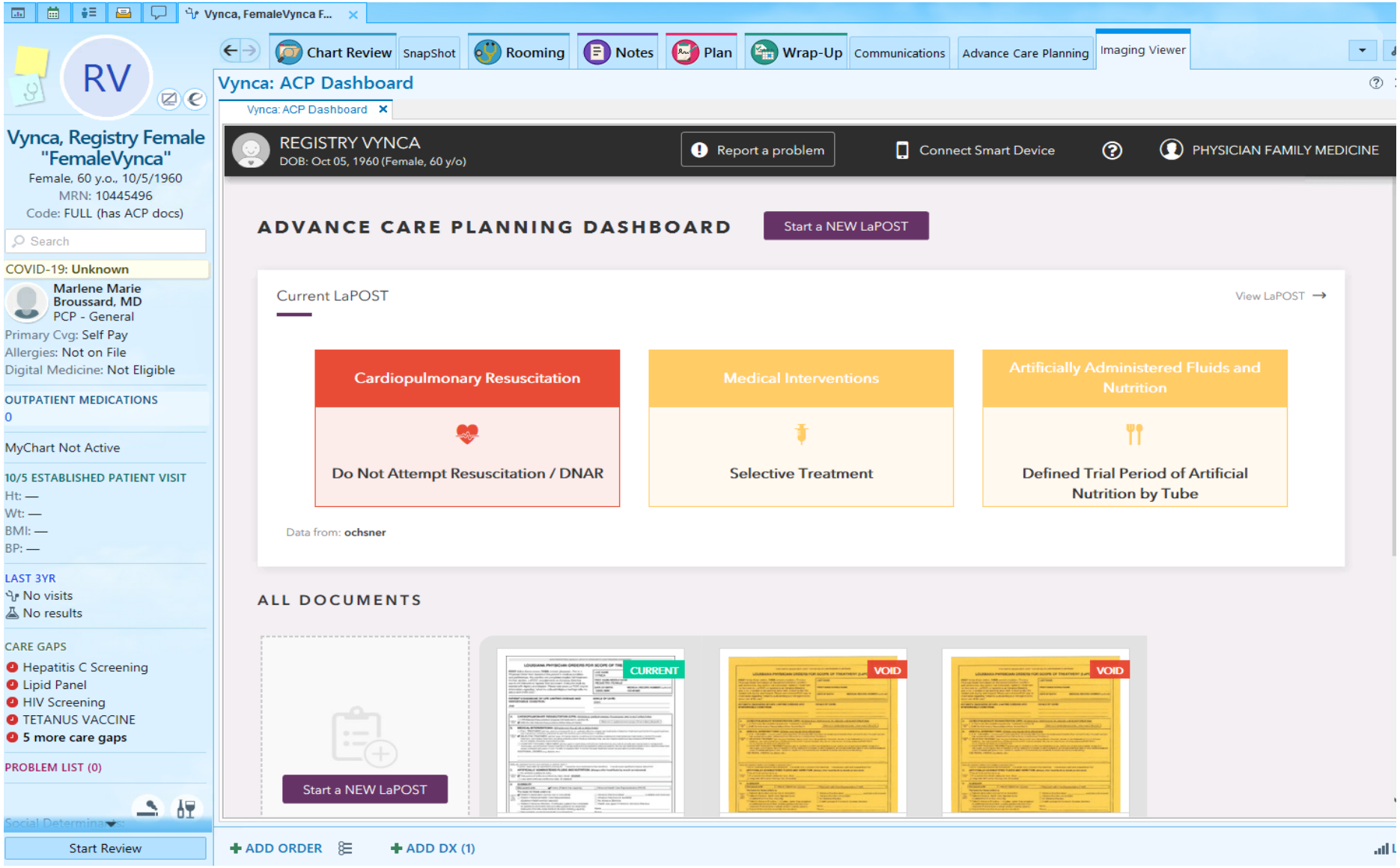
- Appendix

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

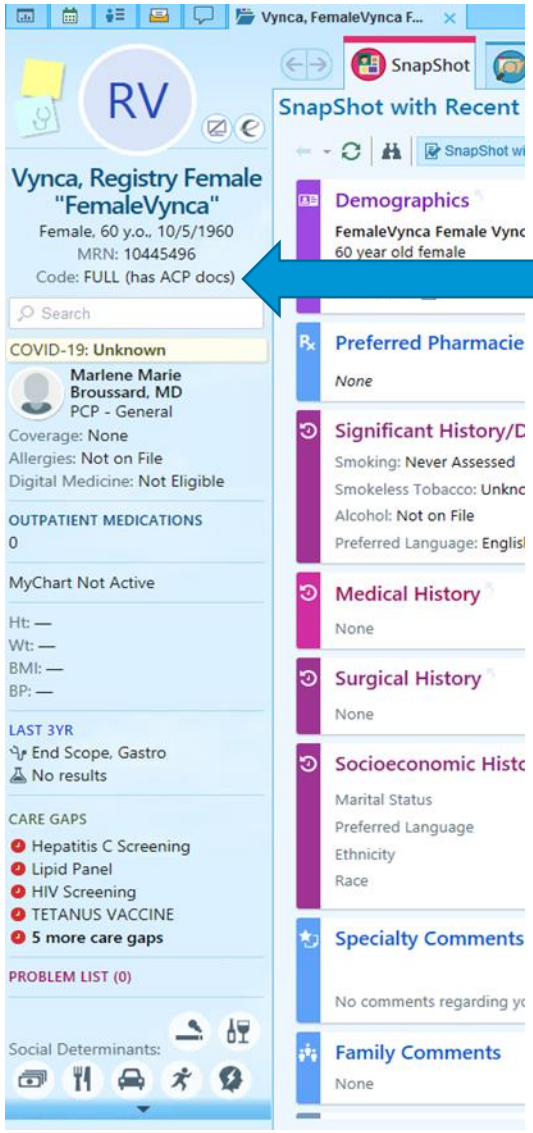


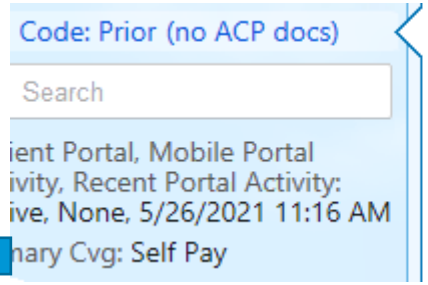


LaPOST Registry



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

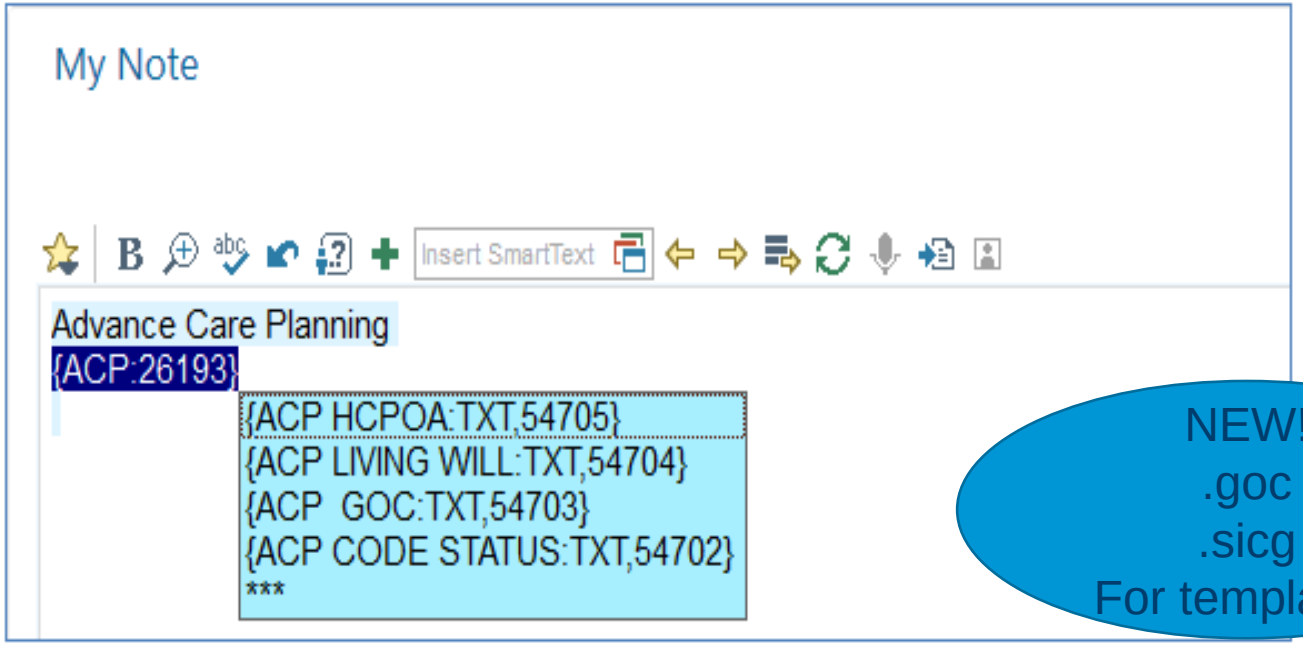
Create ACP Note

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

.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.



I always use:
.acpbegin write narrative note then bookend with **.acpend**

NEW!
.goc
.sicg
For templates!

ACP conversation template (“.GOC” SmartPhrase.)

@ACPBEGIN@

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}

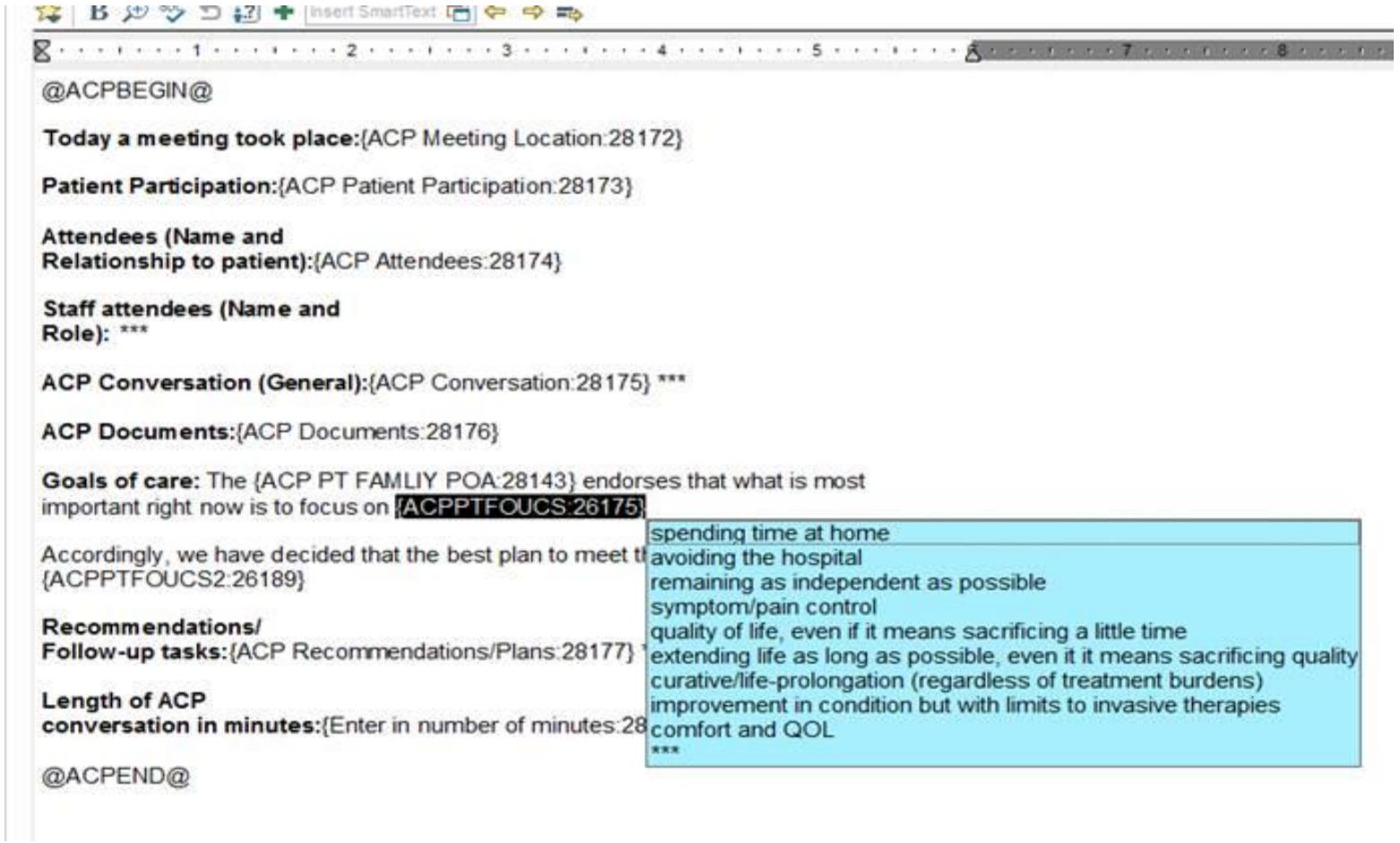
Accordingly, we have decided that the best plan to meet the patient's goals includes {ACPPTFOUCS2:26189}

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

Length of ACP conversation in minutes:{Enter in number of minutes:28178}

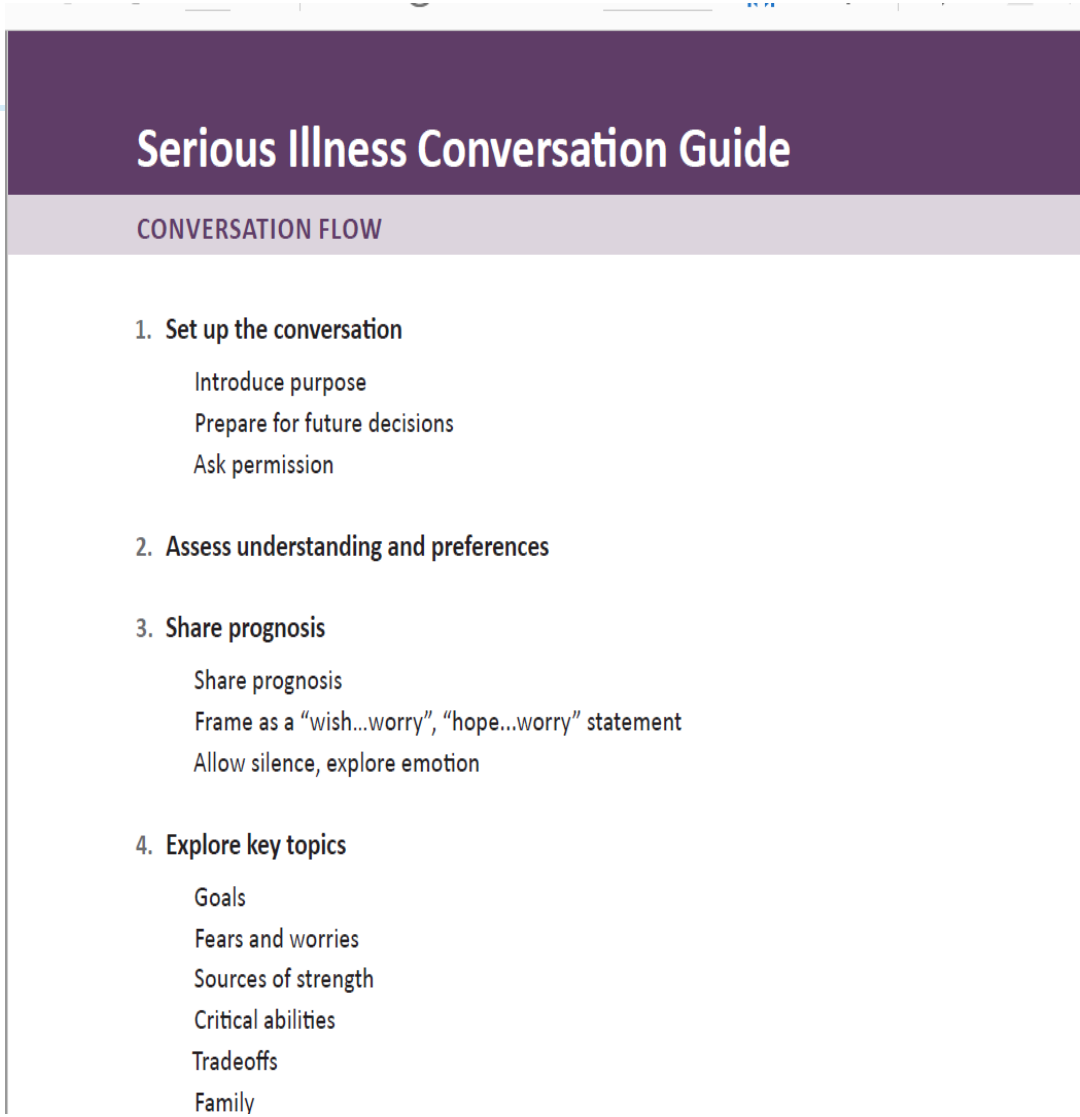
@ACPEND@

ACP conversation template



Serious Illness Conversation Guide

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

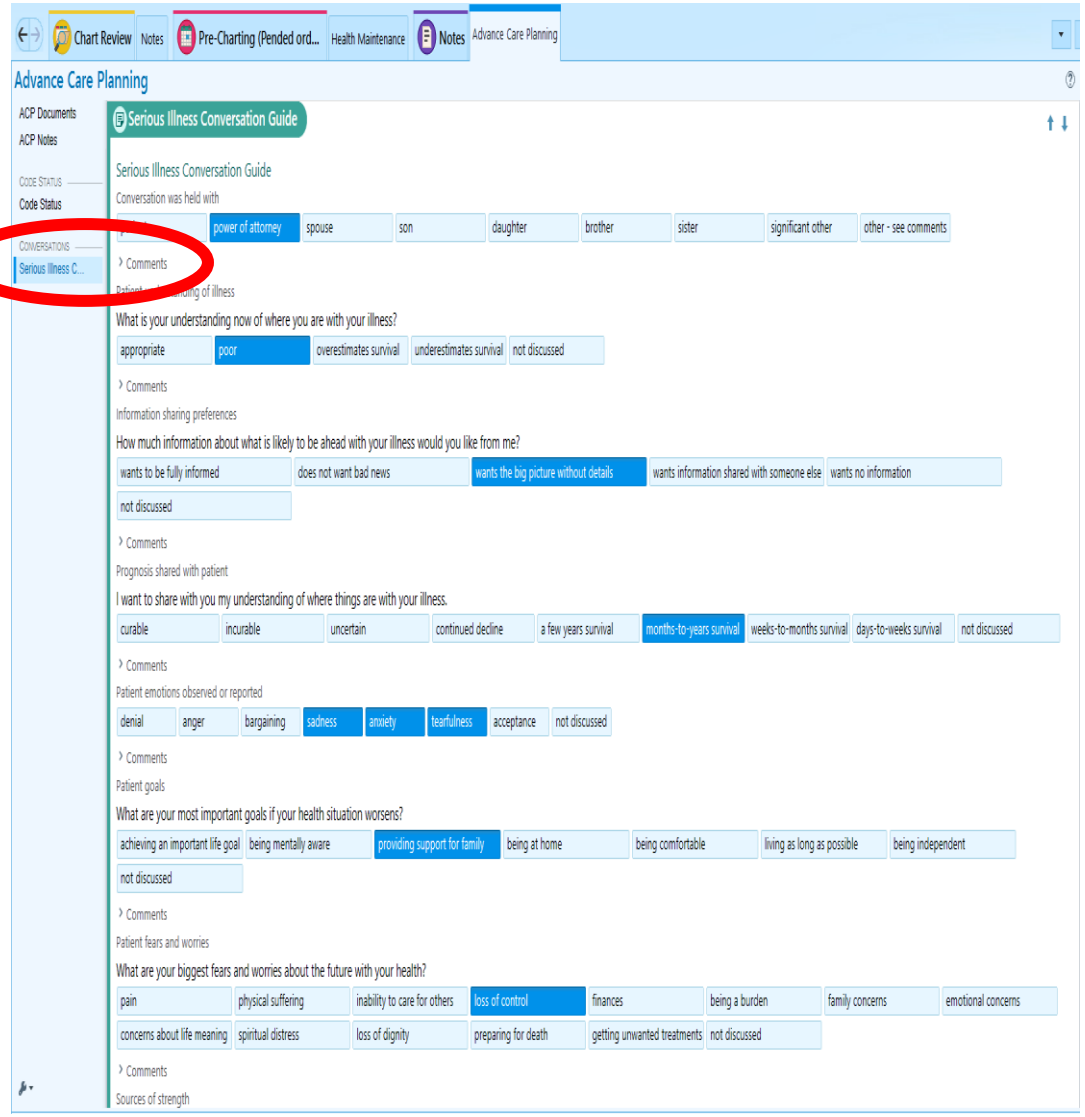


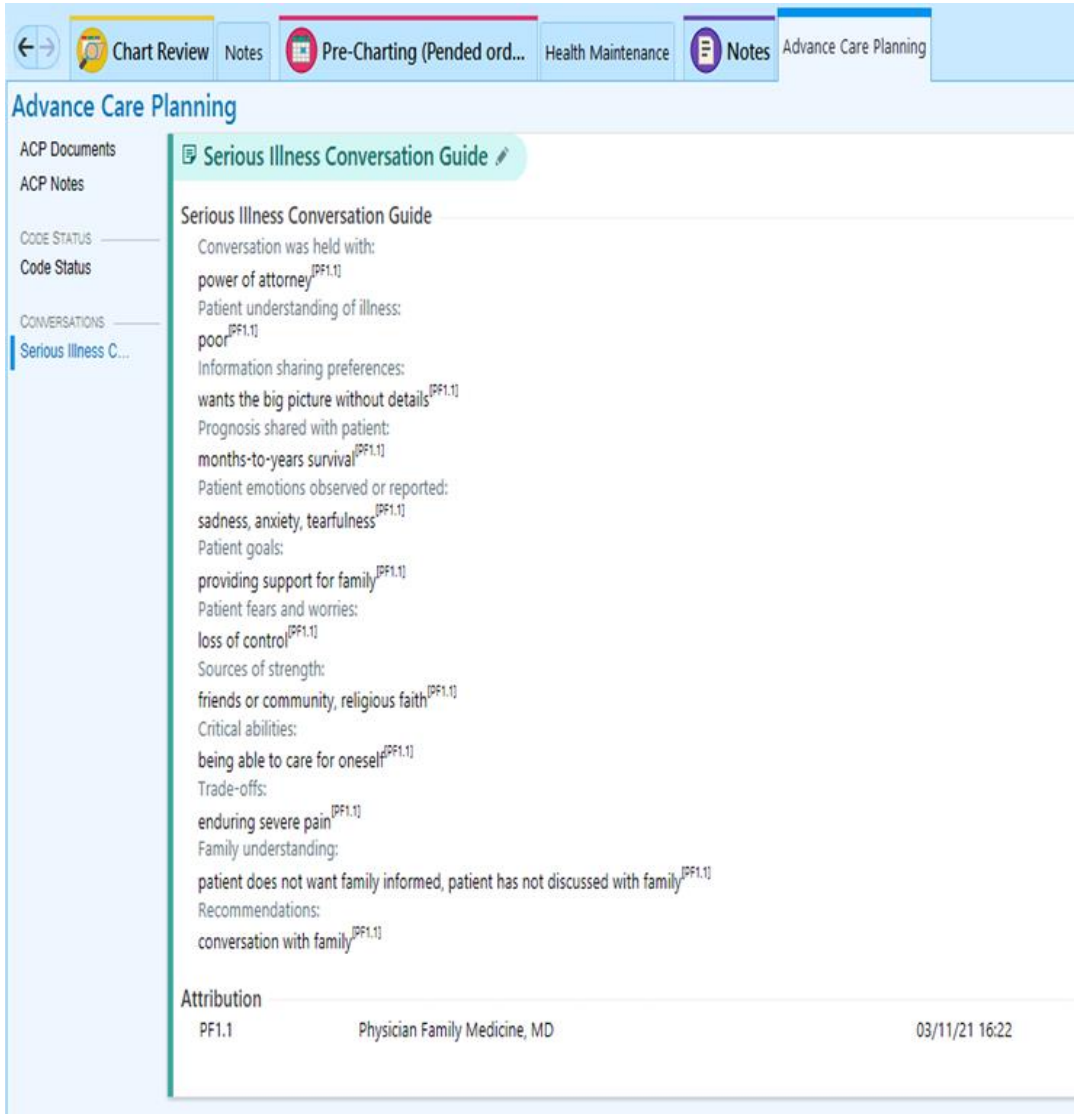
Serious Illness Conversation Guide

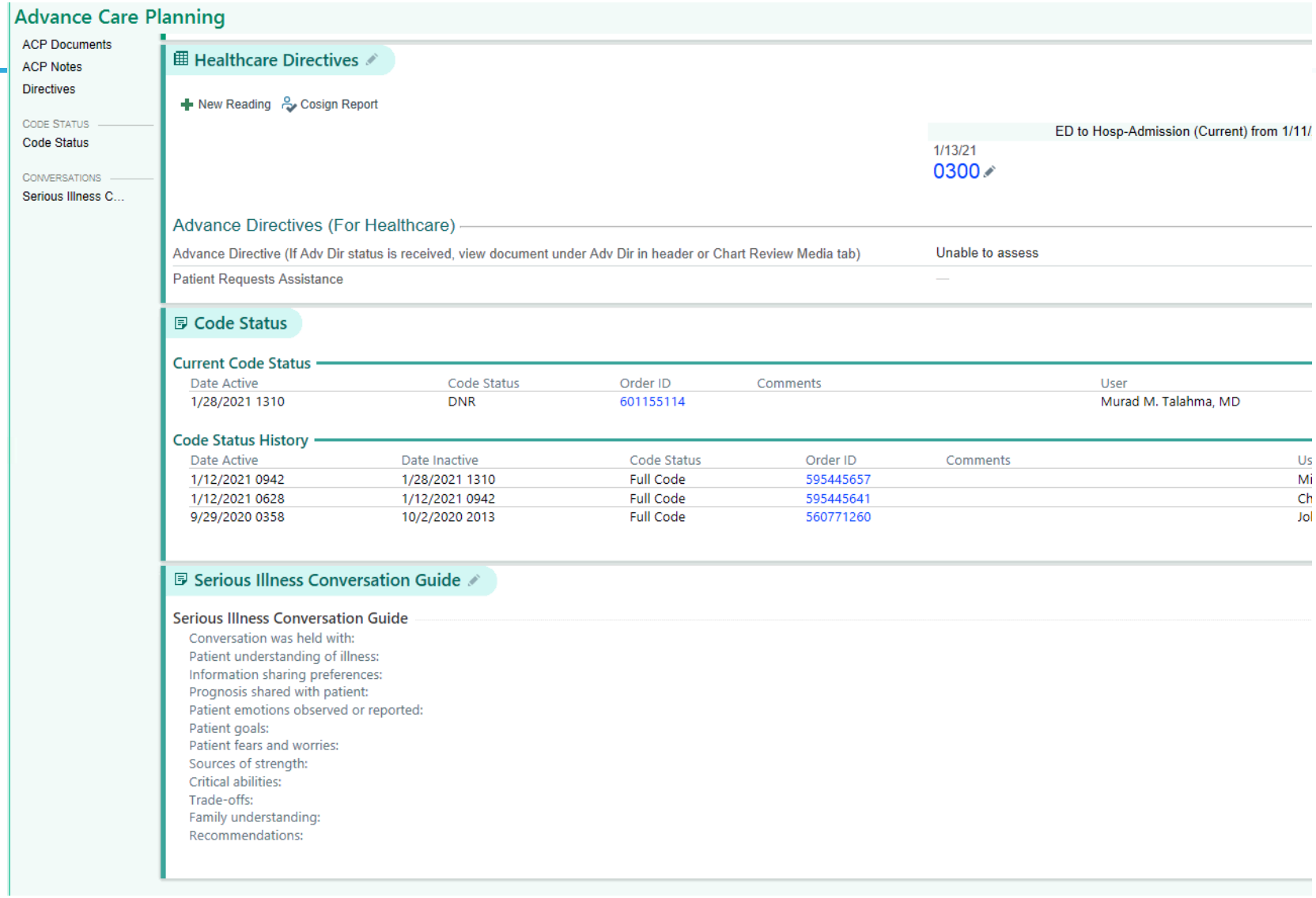
CONVERSATION FLOW

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

Serious Illness Conversation Guide (.sicg)






Advance Care Planning
ACP Documents
ACP Notes
Directives
CODE STATUS
Code Status
CONVERSATIONS
Serious Illness C...
Healthcare Directives
New Reading
Cosign Report
ED to Hosp-Admission (Current) from 1/11/
1/13/21
0300
Advance Directives (For Healthcare)
Advance Directive (If Adv Dir status is received, view document under Adv Dir in header or Chart Review Media tab)
Unable to assess
Patient Requests Assistance
Code Status
Current Code Status
Date Active
Code Status
Order ID
Comments
User
1/28/2021 1310
DNR
601155114
Murad M. Talahma, MD
Code Status History
Date Active
Date Inactive
Code Status
Order ID
Comments
Us
1/12/2021 0942
1/28/2021 1310
Full Code
595445657
Mi
1/12/2021 0628
1/12/2021 0942
Full Code
595445641
Ch
9/29/2020 0358
10/2/2020 2013
Full Code
560771260
Jol
Serious Illness Conversation Guide
Serious Illness Conversation Guide
Conversation was held with:
Patient understanding of illness:
Information sharing preferences:
Prognosis shared with patient:
Patient emotions observed or reported:
Patient goals:
Patient fears and worries:
Sources of strength:
Critical abilities:
Trade-offs:
Family understanding:
Recommendations:

Advance Care Planning

ACP Documents
ACP Notes
Directives

CODE STATUS
Code Status

CONVERSATIONS
Serious Illness C...

Code Status History

Date Active	Date Inactive	Code Status	Order ID	Comments
1/12/2021 0942	1/28/2021 1310	Full Code	595445657	
1/12/2021 0628	1/12/2021 0942	Full Code	595445641	
9/29/2020 0358	10/2/2020 2013	Full Code	560771260	

Serious Illness Conversation Guide

Serious Illness Conversation Guide

Conversation was held with:
daughter[TM1.1]
Patient understanding of illness:
underestimates survival[TM1.1]
Information sharing preferences:
does not want bad news[TM1.1]
Prognosis shared with patient:
curable[TM1.1]
Patient emotions observed or reported:
denial[TM1.1]
Patient goals:
achieving an important life goal, providing support for family[TM1.1]
Patient fears and worries:
pain, physical suffering[TM1.1]
Sources of strength:
family, friends or community[TM1.1]
Critical abilities:
communicating with others[TM1.1]
Trade-offs:
being on a ventilator, being in the ICU[TM1.1]
Family understanding:
patient does not want family informed, patient has not discussed with family, patient wants help discussing with family[TM1.1]
Recommendations:
advance directive, POLST or MOLST[TM1.1]

Attribution

TM1.1	Thomas D. Morel, MD	02/22/21 10:11

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.

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”

Ochsner Health

Why is this 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

Access CAPC's COVID-19 rapid response resources

capc

Resources Clinical Training Connect Events Jobs Membership About Search Login/Create Account

Create an Account

Check if your organization is a CAPC member as the first step to creating your own user account. Once your account is created, you'll have free access to all member resources.

Organization Required

och

Bellbrook Senior Community (FKA: Sanctuary At Bellbrook) - Rochester Hills, MI

Elder ONE - Rochester, NY

Mayo Clinic Hospital - Rochester (St Marys Hospital) - Rochester, MN

Ochsner Medical Center - Main Campus - New Orleans, LA

Please sign in

Center to Advance Palliative Care™

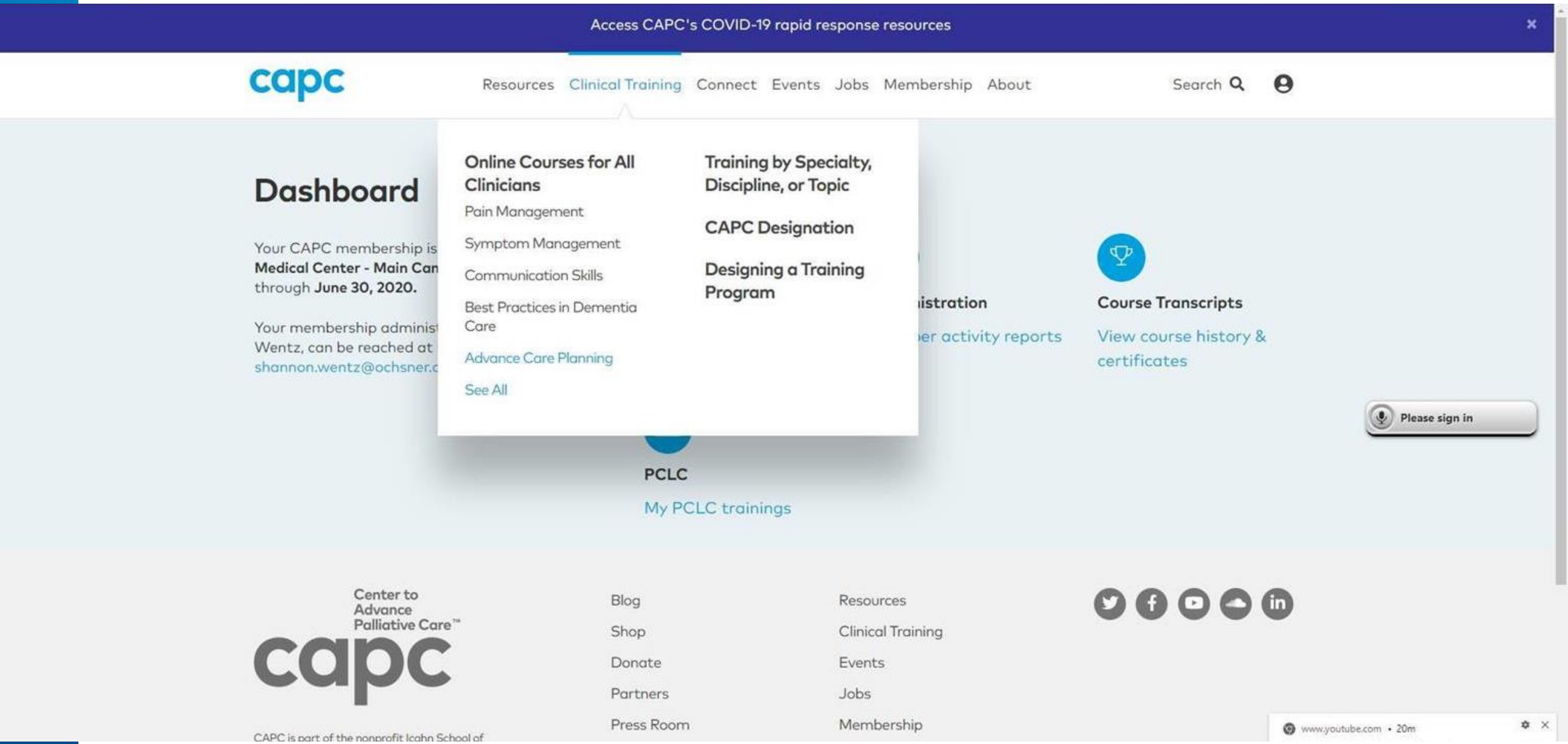
capc

CAPC is part of the nonprofit Icahn School of Medicine at Mount Sinai.

Donate
Partners
Press Room
Privacy Policy
Contact

Events
Jobs
Membership
About

www.youtube.com • 19m


Access CAPC's COVID-19 rapid response resources
capc
Resources
Clinical Training
Connect
Events
Jobs
Membership
About
Search
Online Courses for All Clinicians
Pain Management
Symptom Management
Communication Skills
Best Practices in Dementia Care
Advance Care Planning
See All
Training by Specialty, Discipline, or Topic
CAPC Designation
Designing a Training Program
Dashboard
Your CAPC membership is
Medical Center - Main Can
through June 30, 2020.
Your membership adminis
Wentz, can be reached at
shannon.wentz@ochsner.c
istration
er activity reports
Course Transcripts
View course history & certificates
Please sign in
PCLC
My PCLC trainings
Center to Advance Palliative Care™
capc
CAPC is part of the nonprofit Icahn School of
Blog
Shop
Donate
Partners
Press Room
Resources
Clinical Training
Events
Jobs
Membership
www.youtube.com • 20m

Access CAPC's COVID-19 rapid response resources

capc

Resources Clinical Training Connect Events Jobs Membership About

Search

Building Physician Skills in Basic Advance Care Planning

What You'll Learn

Authored by Respecting Choices®, this three-course online curriculum is intended to build person-centered advance care planning (ACP) skills. While courses use the POLST framework and provide continuing education for physicians and advanced practitioners only, course content may be useful for health professionals from all disciplines. The courses assist clinicians in identifying practical steps to integrate ACP into their everyday practice, especially for their patients who have not started the planning process.

Each course builds incrementally toward this goal. The first two courses provide foundational skills to introduce ACP, motivate patients to participate, as well as conduct and document these essential conversations. The third course identifies ways for physicians and advanced practitioners to integrate ACP into

What You'll Earn

Complete all courses in this series to earn the following continuing education credits :

- Medicine: 2.50 CME

Note: Eligible learners receive ABIM Maintenance of Certification points upon completion of all three courses in the unit.

Need to change which credits you'd like to earn?

The continuing education values listed on this page apply to the current term of accreditation for the courses in this unit. See individual course pages for more information about the accrediting bodies.

Please sign in

www.youtube.com • 21m

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.

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

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]

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.

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

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."

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.