Advance Care Planning- It Always Seems to Early, Until It's Too Late

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1

Objectives

1. Identify three measures to bring awareness of Advance Care Planning (ACP) to your facility.
2. Describe two action steps to educate colleagues about ACP conversations.
3. Differentiate two distinctions between a healthcare directive and a POLST form.

Challenge: Plan and have your own conversations about your choices, values, and wishes.

2

Advance Care Planning: *Definition*

A person-centered, ongoing process of communication that facilitates individuals' understanding, reflection and discussion of their goals, values and preferences for future healthcare decisions.

Respecting Choices®
Gunderson Health System
http://www.gundersenhealth.org/respecting-choices

3

3

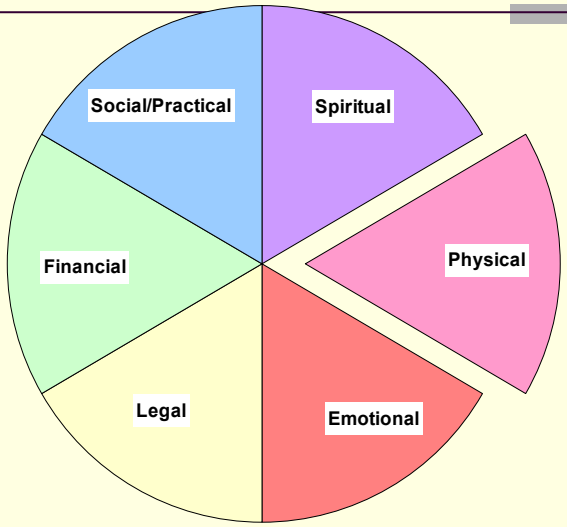
Why Advance Care Planning? Patient Self-Determination Act (1990)

- All Medicare-participating healthcare facilities must inquire about and provide information to patients on Advance Directives
- All facilities must provide community education on Advance Directives
- All healthcare facilities are required to:
  - Provide information about health care decision-making rights.
  - Ask all patients if they have an advance directive.
  - Educate their staff and community about advance directives.
  - Not discriminate against patients based on an advance directive status.

4

Advance Care Planning

Whole Person Planning



Compassion and Support at the End of Life

5

Advance Care Planning: *No Easy Talk*

Perspective: Individuals/Families

- Don't want to talk about death
- Culture and ethnicity
- Lack of awareness and importance of ACP
- Not understanding the significance of condition
- Unclear treatment options and decisions
- Family conflict
- No designated health care agent

Reference: IOM (Institute of Medicine). 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life.* Washington, DC: The National Academies Press.

6

6

Advance Care Planning: *No Easy Talk (cont)*

Perspective: Delivery of Person-Centered Care

- Experience multiple transitions near end of life → high rates of preventable hospitalizations
- Increasing demand for family caregiving → personal care, household tasks, medication management → burden
- Delayed referral to palliative care → access

Reference: IOM (Institute of Medicine). 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life.* Washington, DC: The National Academies Press.

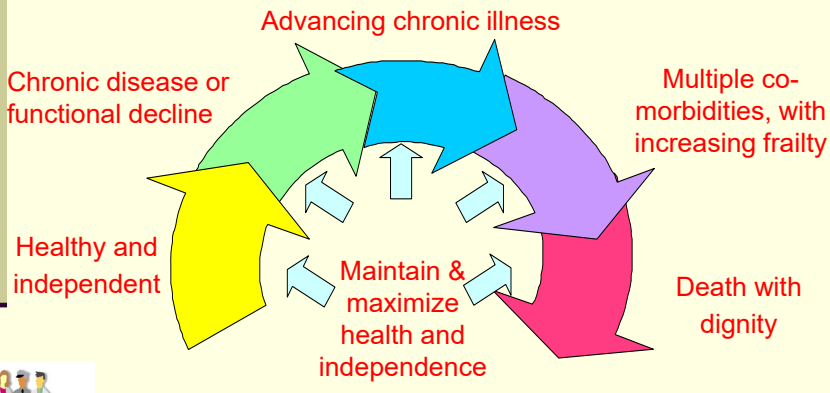
7

7

Advance Care Planning

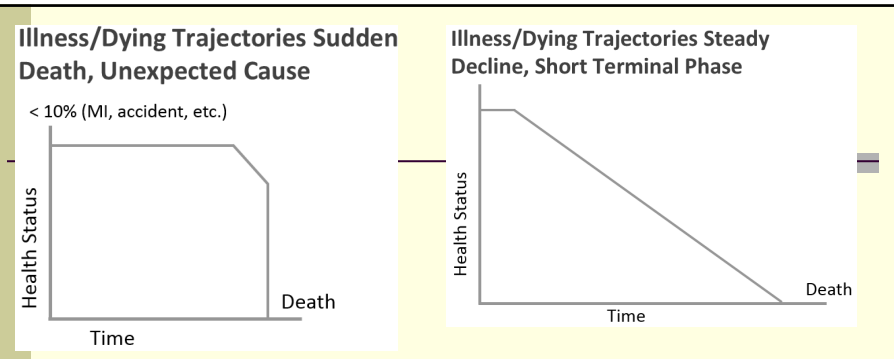
MOLST
MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT

Compassion, Support and Education along the Continuum



Compassion and Support at the End of Life

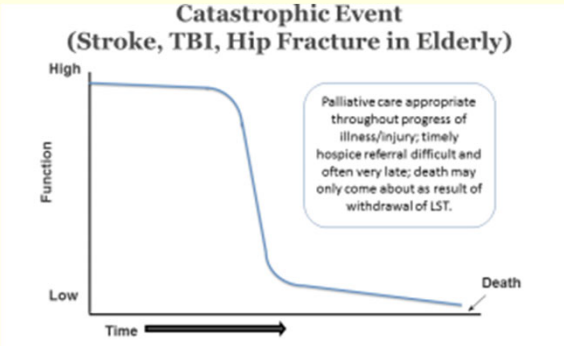
8



ELNEC, 2019

9

The 5th Trajectory



Ballentine, 2018- The Five Trajectories- Supporting Patients During Serious Illness

10

Serious Illness

A health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregiver.*

*Kelley, AS, Bollens-Lund, E. Identifying the population with serious illness: the "denominator" challenge. Journal of Palliative Medicine. Volume: 21 Issue S2: March 1, 2018.

11

Resource People

- Social Workers, Chaplains, Hospital Supervisors, Palliative Care Team
- Provide information about healthcare directives to patients/families who wish to have more information
- Assist patients in completing healthcare directives
- Other staff are not designated to do Healthcare Directives.

12

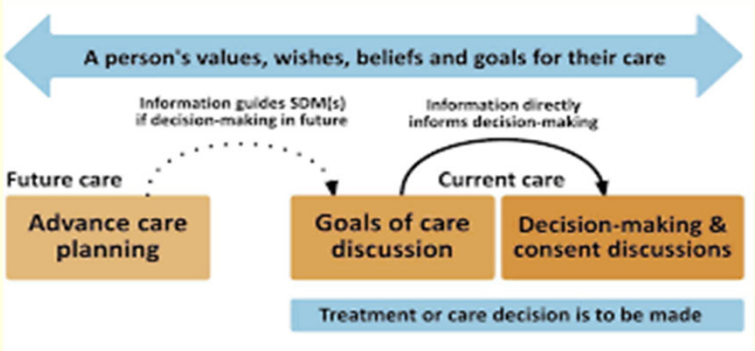
Who Initiates the Discussion?

- Many physicians feel they lack experience in discussing the issues that come with progressive, debilitating illnesses
- The more a provider/healthcare professional prepares for discussions and practices, the more skilled that provider becomes

13

Communication and Goals of Care

- Patient's wishes, preferences
- Goals of Care Planning
- Code Level Discussion
- POLST
- Resuscitative Statistics
- Healthcare Directives



14

Why "What Matters" Matters Most?

- For older adults
  - Variation in "What Matters" Most
  - Feel more engaged and listened to
  - Avoids unwanted treatment while receiving treatment
  - Comfort care Always, not just Only
- For Health systems
  - Better patient experience scores & retention
  - Avoids unnecessary utilization
- For Everyone (patients, families, caregivers, providers, health systems)
  - Everyone is on the same page
  - Improved relationships
  - It is the basis of everything else

15

What to Discuss/Consider?

- What is important to you today?
- What brings you joy?
- What gives your life meaning?
- What makes you happy?
- What makes life worth living?
- What do you worry about?
- What are some goals you hope to achieve in the next six months or before your next birthday?
- What are some goals you hope to achieve in the next six months or before your next birthday?
- What would make tomorrow a really great day for you?
- What else would you like us to know about you?
- How do you learn best? For example, listening to someone, reading materials, watching a video.

16

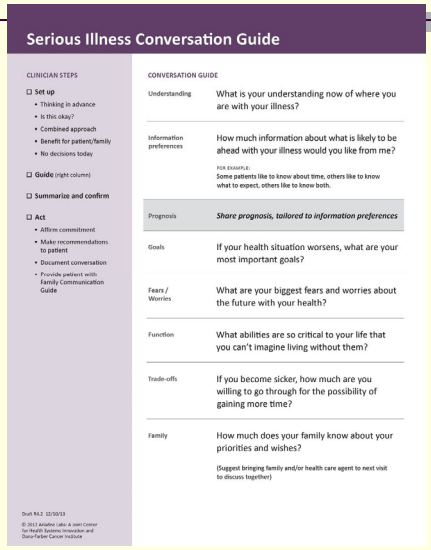
Checklist for Culturally Appropriate "What Matters" Conversations

- Learn the preferred term for their cultural identity
- Determine appropriate degree of formality-how to address
- Determine preferred language. Include an interpreter/materials
- Be respectful of nonverbal communication
- Address issues linked to culture- lack of trust, fear (medical experience, side effects, Western medicine)
- Review history- trauma, violence, survivors of racism (very sensitive)
- Recognize health beliefs- alternative therapies
- Consider decision-making factors and individual autonomy

(Reference: IHI toolkit, 2014)

17

Serious Illness Conversation Guide



Serious Illness Conversation Guide

CLINICIAN STEPS

☐ **Set up**
- Thinking in advance
- Is this okay?
- Combined approach
- Benefit for patient/family
- No decisions today

☐ **Guide** (right column)

☐ **Summarize and confirm**

☐ **Act**
- Affirm commitment
- Make recommendations to patient
- Document conversation
- Provide patient with Family Communication Guide

Draft 9A.2 12/10/13

CONVERSATION GUIDE

Understanding	What is your understanding now of where you are with your illness?
Information preferences	How much information about what is likely to be ahead with your illness would you like from me? FOR EXAMPLE: Some patients like to know about time, others like to know what to expect, others like to know both.
Prognosis	*Share prognosis, tailored to information preferences*
Goals	If your health situation worsens, what are your most important goals?
Fears / Worries	What are your biggest fears and worries about the future with your health?
Function	What abilities are so critical to your life that you can't imagine living without them?
Trade-offs	If you become sicker, how much are you willing to go through for the possibility of gaining more time?
Family	How much does your family know about your priorities and wishes? (Suggest bringing family and/or health care agent to next visit to discuss together)

18

Goals of Care & Treatment Options Discussion

- What is the one thing about your health care you most want to focus on so that you can do [fill in desired activity] more often or more easily?
- What are your most important goals now and as you think about the future with your health?
- What concerns you most when you think about your health and health care in the future?
- What are your fears or concerns for your family?
- What are your most important goals if your health situation worsens?
- What things about your health care do you think aren't helping you and you find too bothersome or difficult?
- Is there anyone who should be part of this conversation with us?

19

AMDA's ACP Discussion Guide
5-S CARE PLAN

5-S
(Environment)

- Scene
- Setting
- Seating
- Scenario
- Start with Open Ended Question

P-L-A-N
(Execution)

- Prepare and Plan
- Leave
- Always Affirm
- Note, Navigate and Never Lose Hope

C-A-R-E
(Engagement)

- Consider and Clarify
- Assess and Assume Not
- Reflect and Respond
- Evaluate and Execute

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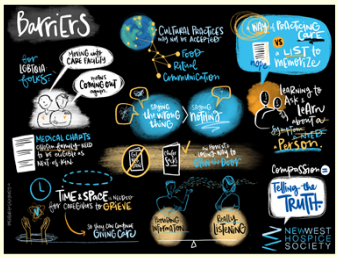
20

Barriers to Completing Advance Directives

- Physicians do not feel the discussion is appropriate in an outpatient setting
- Many people think a financial power of attorney covers them
- Many people think advance directive means do not treat
- People fear advance directive means they lose control of their own care
- Only old people need advance directives



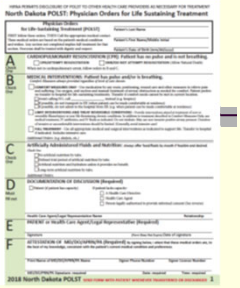
21

WHAT IS POLST?

22

What is POLST/MOST?

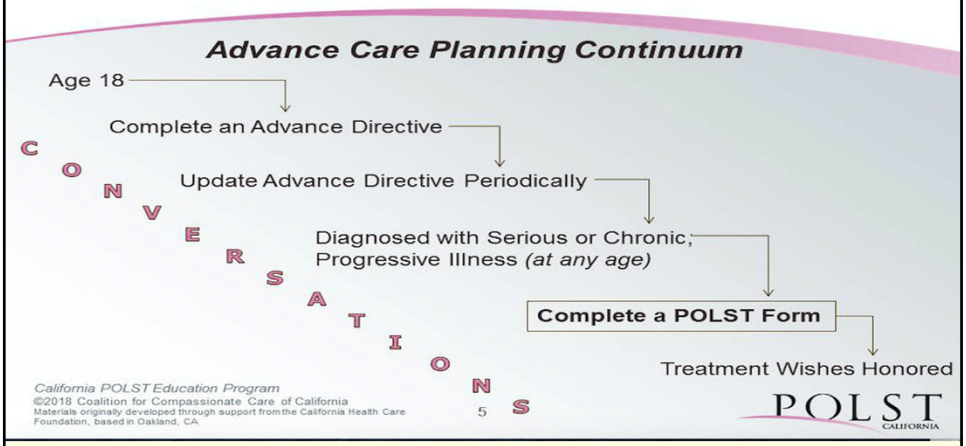
- Medical Order
- Signed by the patient or their Agent
- Signed by a Physician or Advanced Practice Provider
- PORTABLE from one facility to another and honored by EMS


North Dakota POLST: Physician Orders for Life Sustaining Treatment


MEDICAL ORDERS FOR SCOPE OF TREATMENT
SOUTH DAKOTA MOST

23

Where Does POLST Fit In?



24

Comparing POLST Form to Healthcare Directive

	Healthcare Directive	POLST Paradigm Forms
Population	All adults >18 y.o.	Any age, serious illness, at end of life or frailty
Time Frame	Future care/future conditions	Current care/current conditions
Where Completed	Any setting, not necessarily medical	Medical setting
Resulting Product	Healthcare agent appointed and/or statement of preferences	Medical orders based on shared decision making
Healthcare Agent Role	Cannot complete	Can consent if patient lacks capacity
EMS Role	Does not guide EMS	Guides EMS as a medical order
Portability	Patient/Family Responsibility	Healthcare Professional Responsibility
Periodic Review	Patient/Family Responsibility	Healthcare Professional Responsibility

25

How Hope Grows & Other POLST Videos

- https://polst.org/

26

NATIONAL HEALTHCARE DECISIONS DAY

your decisions matter

- Initiative is a collaborative effort of national, state and community organizations
- Committed to ensuring that all adults with decision-making capacity in the United States have the information and opportunity to communicate and document their healthcare decisions
- April 16th each year (started 2008)

https://theconversationproject.org/nhdd/

27

Tools to Get Started

- Go Wish Game
- Serious Illness Care Resources
- The Conversation Project Starter Kits
- National Healthcare Decisions Day- April 16
- MyDirectives app
- Honoring Choices® North Dakota
- LifeCircle South Dakota

28

Healthcare Directive & POLST Resources

- ND- Short Form, Long Form
- ND- POLST
- SD- Comfort ONE
- SD- MOST
- National POLST
- Article, *The Pearls of POLST*

29

When to Start?

TODAY!

First and foremost, lead by example - be sure you have thoughtfully considered and made your own healthcare decisions known.

"The future depends on what we do in the present"

–Mahatma Gandhi

30

Conclusions

- There are numerous methods and materials to bring awareness of Advance Care Planning (ACP) to your facility.
- Remember to educate your colleagues about ACP conversations.
- Conversations first then create a healthcare directive and/or a POLST form.
- The Challenge:

Plan and have your own conversations about your choices, values and wishes.

31

For More Information

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32