Advance care Planning and Goals of Care- What Every Person Should Know

Sivan Ben-Moshe, MD
Assistant Professor of Geriatric Medicine
Division of Geriatrics and Gerontology, Department of Medicine
sbenmos@emory.edu

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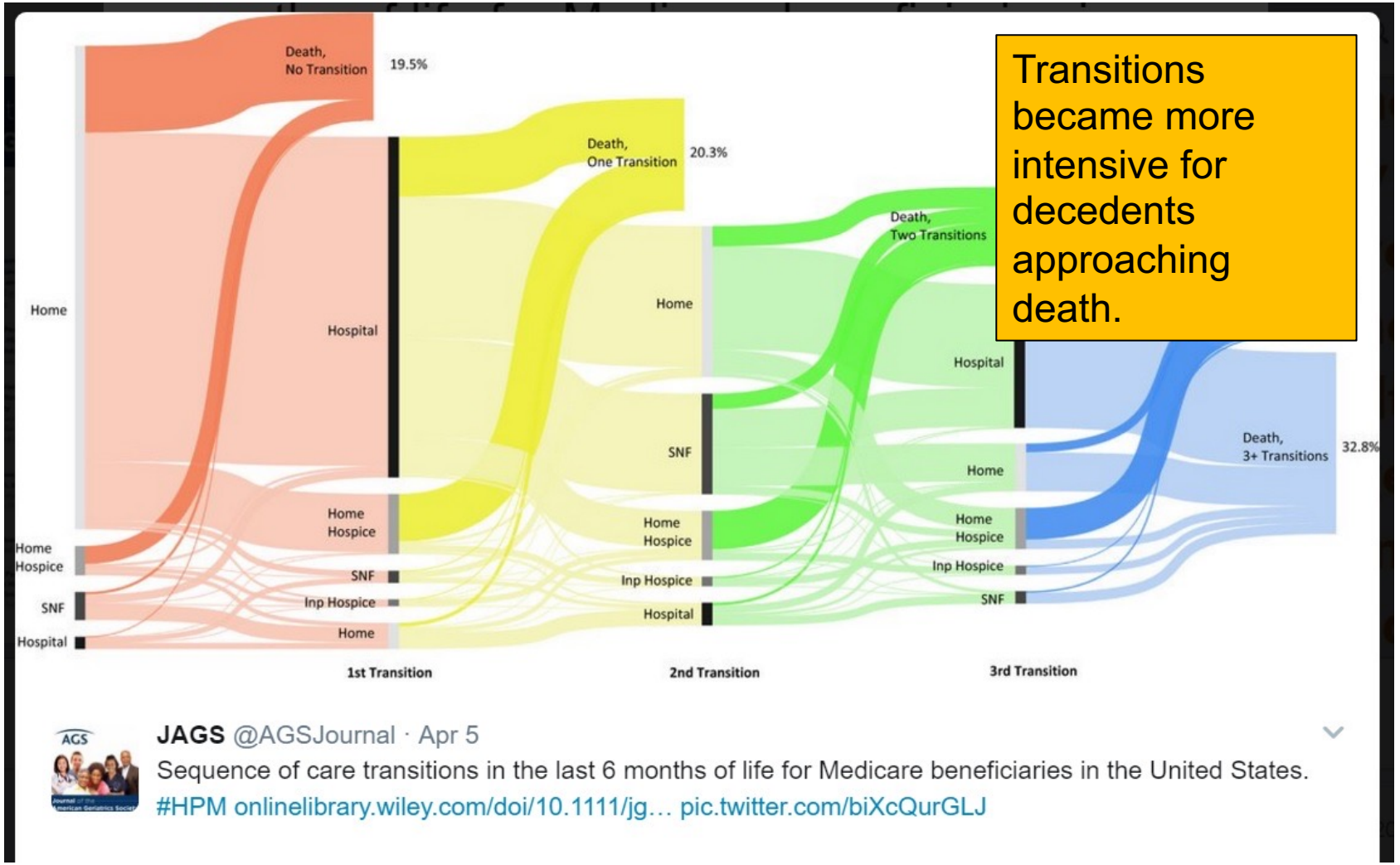
Objectives

- Discuss benefits to having goals of care discussions
- Familiarize advance care planning definition
- Learn how to chose a health care proxy
- Identify key elements in ACP documentation
- Important questions to ask yourself about Serious Illness



http://onlinelibrary.wiley.com/doi/10.1111/jgs.14891/full

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Good care starts with goal-directed care

Advance care planning

2017 a large Delphi panel agreed on a consensus definition as “a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.”

Barriers

- Clinicians are afraid to discuss with patients
- Patients afraid to talk about death, or culturally unable to
- Clinician doesn’t know how to discuss, never had training
- Patient and/ or clinician do not know how to document

Conversations

Who?
What?
When?
Where?
Why?

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Why?

The reason for ACP initially was to be able to honor patient's wishes, especially when something unpredictable happened. It was to avoid family disputes and legal cases.

- ✓ Roadmap
- ✓ For the patients, but also those caring for them and the burden they may carry.
- ✓ Studies have shown that it decreases burnout for providers
- ✓ The actual conversation is part of the intervention in that patients and caregivers need to feel heard.

Who?

1) Primary Care Provider ideally
2) Staff (Social Worker, RN, Trainees)
3) Consultants- Neurologist, Oncologist etc
Advanced practice provider- NP, PA

Although attorneys currently do some of this, it is not required and not recommended by health professionals

What?

1) Identify a Health care surrogate

2) Discuss goals of care with the patient and surrogate or encourage patient to do this.

3) Document the wishes on an official form

How?

Health Care Surrogate/Proxy

Because of accidents or illness, 3 out of 4 people (75% of people) will be unable to make some or all of their own medical decisions at the end of life. If this happens, doctors need to know who can make decisions for you.

Health Care Proxy

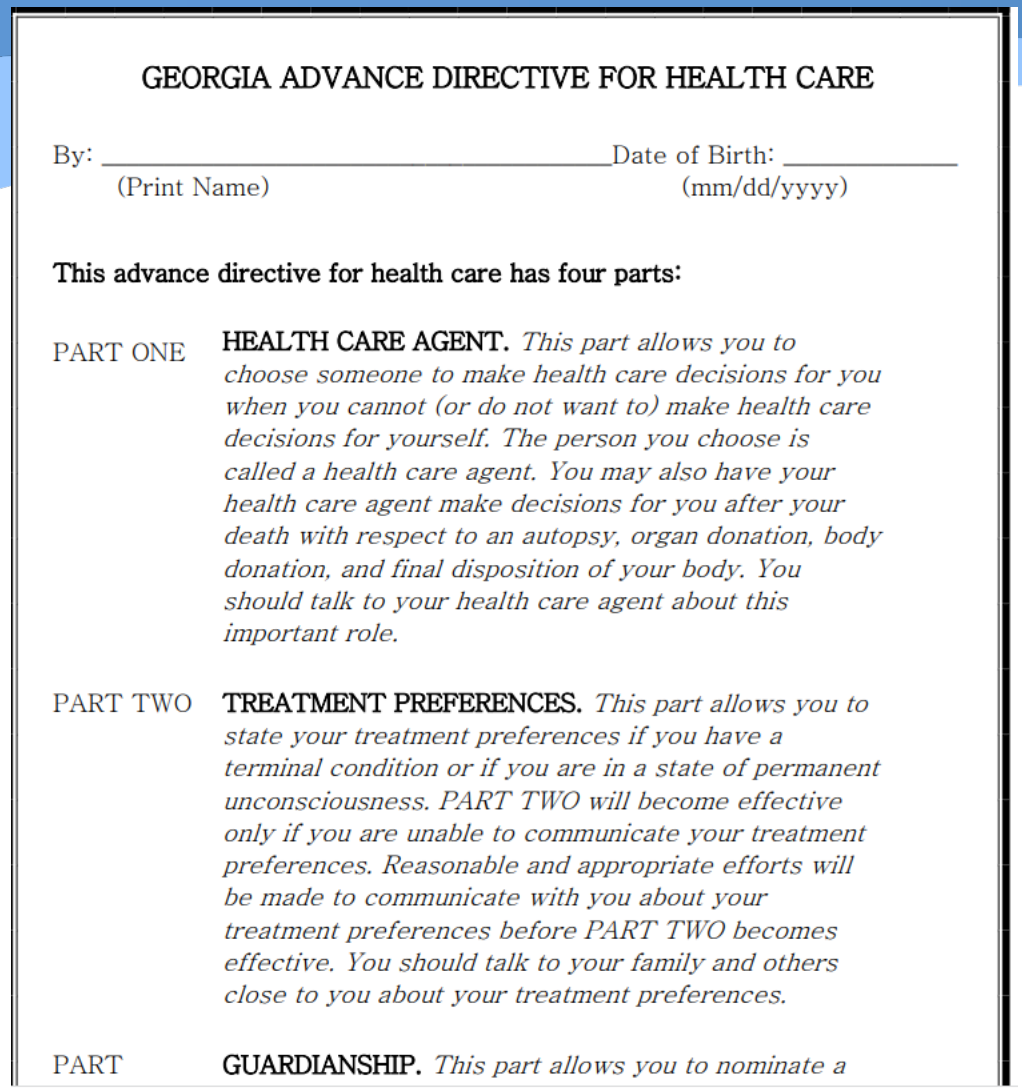
Why is it important to have a HCP?

Health Care surrogate

www.prepareforyourcare.org

Step 1: Choose a Medical Decision Maker
Step 2: Decide What Matters Most in Life
Step 3: Choose Flexibility for Your Decision Maker
Step 4: Tell Others About Your Wishes
Step 5: Ask Doctors the Right Questions

Documentation



GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

By: _____ Date of Birth: _____
(Print Name) (mm/dd/yyyy)

This advance directive for health care has four parts:

PART ONE **HEALTH CARE AGENT.** *This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.*

PART TWO **TREATMENT PREFERENCES.** *This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.*

PART **GUARDIANSHIP.** *This part allows you to nominate a*

Requirements for the person making an advance directive for health care
- Must be of sound mind
- Must be 18 years of age or older Or An emancipated minor

Executing the advance directive for health care
1) the declarant must sign or expressly direct someone else do it for him/her
2) two witnesses required, who are
   - of sound mind
   - 18 years of age or older
   - Witnesses do not have to see the declarant sign
   - Witnesses do not have to see each other sign the advance directive

3) the declarant must see both witnesses sign
4) Restriction on witnesses
   - Not the health care agent
   - Not knowingly be in line to inherit anything from or benefit from the death of the declarant
   - Not directly involved in the health care of the declarant
   - Only one of the two witnesses can be an employee, agent or on the medical staff of the health care facility where the declarant is receiving his/her health care

YOU DO NOT NEED AN ATTORNEY OR A NOTARY

Georgia Department of Public Health

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

Patient's Name _____ _____ _____
(First) (Middle) (Last)

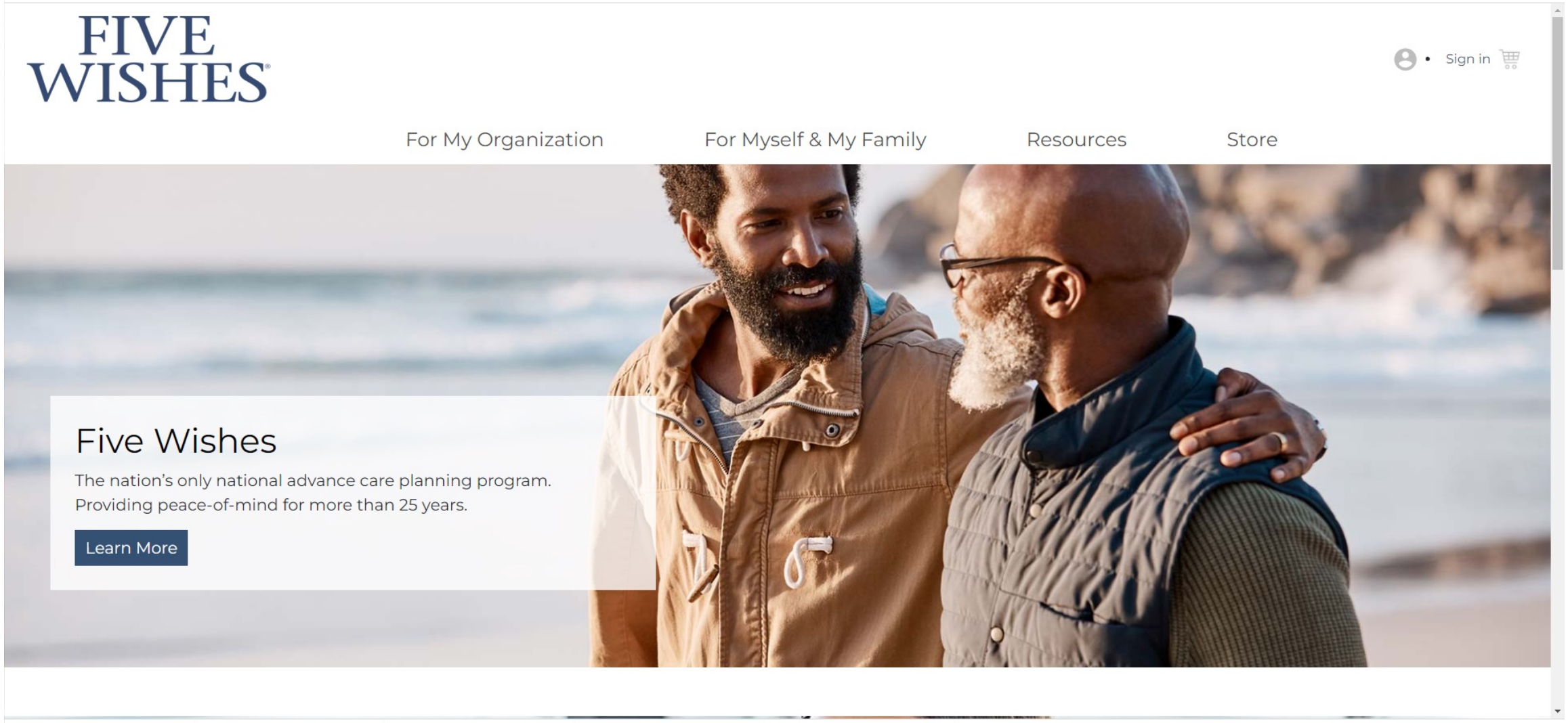
Date of Birth _____ **Gender**: Male ☐ Female ☐

A **CODE STATUS** Check One	**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.** ☐ **Attempt Resuscitation (CPR).** ☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.** ***Signature of a concurring physician is needed for this section to be valid if this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.* **When not in cardiopulmonary arrest, follow orders in B, C and D.**
B Check One	**MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.** ☐ **Comfort Measures**: Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment.* ☐ **Limited Additional Interventions**: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. *Transfer to hospital if indicated. Generally avoid intensive care unit.* ☐ **Full Treatment**: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.* Additional Orders (e.g. dialysis):
C Check One	**ANTIBIOTICS** ☐ No antibiotics: Use other measures to relieve symptoms. ☐ Determine use or limitation of antibiotics when infection occurs. ☐ Use antibiotics if life can be prolonged. Additional Orders:
D Check One In Each Column	**ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS** **Where indicated, always offer food or fluids by mouth if feasible** ☐ No artificial nutrition by tube. ☐ Trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. Additional Orders: ☐ No IV fluids. ☐ Trial period of IV fluids. ☐ Long-term IV fluids. Additional Orders:

DISCUSSION AND SIGNATURES

The basis for these orders should be documented in the medical record. To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable Georgia law.

Physician Name:	Physician Signature:	Date:



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When?

- **Post hospital visit**

- *Why were you in the hospital?*
  → Clarify misunderstandings
  →Add additional information

- *Do you feel you are back to your baseline?*
  → *Describe trajectories*
  → *Time for Serious Illness Conversation*

- **Complex decision-** i.e. surgery or difficult procedure to contemplate

When?

- **Annual Wellness Visit**

“ They want to know if you have an advanced directive. Do you know what that is?”

Advanced care planning/ End of Life Planning

- Do you have an advanced directive?: yes/no
- If not, would you like to complete one today?: yes/no

Notes: I discussed GOC with the patient. He wants his wife to be his HCP (wife's name and phone number). He states he wants to be cremated. He has told her that if he ever had an irreversible condition he would not want extraordinary measures to keep him alive. He values his independence, his QOL is most important to him. He states he is excited to wake up in the morning and live life and if that went away he would not want to continue. We went over the GA advanced Directive forms and he will take it home to fill out and discuss with his wife.

The Conversation
Questions to help you talk with your healthcare agent:

- What is Most important to you?
- What Concerns do you have?
- What medical treatments might be too much for you?
- What are your beliefs and values, your cultural or religious thoughts about end of life?

Important Language (Serious Illness Conversation Guide)

- What are you 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?

Take home points

- Pick a proxy
- Make sure they know your wishes
- Document your wishes
- Share your wishes with your healthcare providers

Q &A

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