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

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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
Transitions became more intensive for decedents approaching death.
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?
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.
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?
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
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 each other sign
   Witnesses do not have to see the declarant sign
   Witnesses do not have to see 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
# PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

**Patient's Name**

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<th>First</th>
<th>Middle</th>
<th>Last</th>
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<table>
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<tr>
<th>Date of Birth</th>
<th>Gender: Male [ ] Female [ ]</th>
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**A. CODE STATUS**

- [ ] CODE STATUS: Check One

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**B. MEDICAL INTERVENTIONS**

- [ ] Limited Additional Intervention: 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 congruent care as indicated. Transfer to hospital and/or intensive care unit if indicated.

**C. 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.

**D. ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS**

- [ ] No artificial nutrition by tube.
- [ ] Trial period of artificial nutrition by tube.
- [ ] Long-term artificial nutrition by tube.

**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.

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<th>Physician Name</th>
<th>Physician Signature</th>
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Five Wishes
The nation's only national advance care planning program. Providing peace-of-mind for more than 25 years.
Learn More
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
• 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
References


• https://media.capc.org/recorded-webinars/slides/ACP_Webinar-final-1.pdf