STHS Palliative Care
Advanced Care Planning

Elisabeth Monies, RN
Palliative-Transition Care Supervisor
What Is Palliative Care?
Palliative Care

- Palliative Care is meant to be an extra layer of support for anyone that has a chronic or life-limiting disease.
- Palliative Care looks at the whole patient and support system to make recommendations for physical, psychosocial and spiritual needs.
- Palliative Care can be given at the beginning of diagnosis through the trajectory of the disease(s) to EOL.
- The earlier Palliative Care can establish care in the disease process, the more impact we can make.
Palliative Care vs. Hospice

**Palliative Care**
Multidisciplinary approach to specialized medical care for people with serious illness. Focused on providing patients with relief from physical, mental and spiritual symptoms of serious illness – whatever the diagnosis. Goal is to improve quality of life for both the patient and the family.

**Hospice**
Is palliative care provided when a patient has a life limiting illness and is expected to die in the next 6 months.
What Is Advance Care Planning?
What is Advance Care Planning?

Advance Care Planning (ACP) helps design a treatment strategy or plan for the health care team to follow when patients have a sudden, devastating illness or a serious, advanced illness. This planning allows health care professionals to understand the patient’s goals of care so they match the type of care that they receive.
Living Will
- Gives patients the “right to make choices and decisions about the types and extent of medical care they wish for themselves”
- Patients can specify if they want to accept or refuse specific medical care
- A legal document that requires physician interpretation
- Does not need to be notarized, but does need the document to be witnessed by two people not related by blood or marriage AND would not benefit financially from patient’s death

Health Care Power of Attorney
- Identifies the decision maker when the patient no longer can or no longer desires to make personal health care decisions
- Only goes into effect when the patient is unable to make decisions, even if the family disagrees with the patient’s decisions
- Does not need a lawyer to complete
- Does not need to be notarized but witnessed by two people not related by blood or marriage AND would not benefit financially from patient’s death

LaPOST
- The LaPOST document gives patients with serious advanced illness and frailty the ability to state their own preferences for medical care if they become unable to communicate.
- It is a physician’s order that outlines a patient’s wishes for medical treatment and goals of care when the patient has a known serious, advanced illness.
- The LaPOST document is transferable among health care settings and enhances communication among health care professionals with the patient at the center.
- The LaPOST document may be changed or revoked at any time by the patient or the patient’s health care representative if there is new knowledge of a change in the patient’s medical condition or personal wishes.

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
Hierarchy of Medical Decision-Making
Every state has laws that govern who can make medical decisions for a patient in the event he becomes unable to make medical decisions for himself. The following is the hierarchy of medical decision makers in Louisiana:

- Someone whom the patient has previously designated in writing as the medical decision maker (either by declaration before 2 witnesses or through a written healthcare power of attorney).
- A judicially appointed curator or tutor
- The patient’s spouse, not judicially separated
- Adult children of the patient (by majority)
- The parents of the patient
- The patient’s sibling (by majority)
- The patient’s other relatives (by majority)

Checking ACP in EPIC during hospital admission
Checking ACP in EPIC during clinic visit
Click on LaPOST Registry to view LaPOST documents in EMR, to prepare LaPOST document or sign LaPOST document (physician’s only)
Printing ACP documents in EPIC during clinic visit
**Visit Information**

**Chief Complaint:**
- Difficulty swallowing

**Past Medical History:**
- Diabetes mellitus, type 2
- Diabetes mellitus, type 1

**Medications:**
- None

**Vital Signs:**
- BP: 133/87
- RR: 20
- Temp: 98.5°F
- SpO2: 95%
- Weight: 95.3 lb (214 lb)
- BMI: 36.9 kg/m²
- History: 15 years
- Presenting Problem: Difficulty swallowing

**Social Determinants:**
- None noted

**Home BP Cuff Calibration:**
- Cuff calibration status: 1/2021
EPIC Advance Care Planning Documentation
Type "acp" enter in notes. Templates can be placed anywhere in narrative notes.
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.
"acp" Family Meeting Template
“F2” button will take you through template quickly
My Note

Advance Care Planning

Date: 04/06/2021

Power of Attorney

I initiated the process of advance care planning today and explained the importance of this process to the patient. I introduced the concept of advance directives to the patient, as well. Then the patient received detailed information about the importance of designating a Health Care Power of Attorney (HCPOA). He was also instructed to communicate with this person about their wishes for future healthcare. He should become sick and lose decision-making capacity. The patient has not previously appointed a HCPOA. After our discussion, the patient has decided to complete a HCPOA and has appointed his significant other, health care agent, Mary Smith & health care agent number. I spent a total of 15 minutes discussing this issue with the patient.

Living Will

During this visit, I engaged the patient and family in the advance care planning process. The patient and I reviewed the role for advance directives and their purpose in directing future healthcare if the patient’s unable to speak for him/herself. At this point in time, the patient does not have full decision making capacity. We discussed different extreme health states that he could experience, and reviewed what kind of medical care he would want in those situations. The patient and family communicated that if he were comatose and had little chance of a meaningful recovery, he would not want machines/life-sustaining treatments used. In addition to the above preference, other important end-of-life issues for the patient include: patient wants 2 weeks to make a recovery. If no recovery is possible or poor prognosis is given earlier, patient desires to have life sustaining treatment withdrawn. The patient has completed a living will to reflect these preferences. I spent a total of 20 minutes engaging the patient in this advance care planning discussion.

QOC

I engaged the patient and family in a conversation about advance care planning and we specifically addressed what the goals of care would be moving forward, in light of the patient’s change in clinical status, specifically metastatic cancer. We also specifically addressed the patient’s likely prognosis, which is poor. We explored the patient’s values and preferences for future care. The patient and family endorsed that what is most important right now is to focus on spending time at home, avoiding the hospital, remaining as independent as possible, symptom management, quality of life, etc. Even if it means sacrificing a little time, improvement in condition but without invasive therapies and comfort and QOL.

Accordingly, we have decided that the best plan to meet the patient’s goals includes continuing with treatment.

I will explain the role for hospice care at this stage of the patient’s illness, including its ability to help the patient live with the best quality of life possible. We will not be making a hospice referral.

I spent a total of 25 minutes engaging the patient in this advance care planning discussion.

Code Status

In light of the patient’s advanced and life limiting illness, I engaged the patient and family in a conversation about the patient’s preferences for care at the very end of life. The patient wishes to have a natural, peaceful death. Along those lines, the patient does not wish to have CPR or other invasive treatments performed when his heart and/or breathing stops. I communicated to the patient and family that a DNR order would be placed in the medical record to reflect these preferences and the LIPART form was completed to reflect other EOL preferences of the patient such as DNR, Selective Treatment and no Artificial Nutrition. I spent a total of 20 minutes engaging the patient in this advance care planning discussion.
80 minutes in total spent on ACP

ACP Code #99497 for 1st 30 minutes

ACP Modifier Code #99498 x 2 for additional 50 minutes

total of 15 minutes discussing
“Serious Illness” Guide in EPIC
offers a working template for staff to have higher quality, patient-centered conversations.

Offers framework for staff to feel confident and empowered to have conversations with patients & caregivers.

Can be completed by providers, nurses, social workers and chaplains.

Enables Goals of Care to be an ongoing discussion, not a single conversation.

Ensures we are providing the right care, at the right time to the right patient.

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**EPIC “Serious Illness” Template**

EPIC Serious Illness Guide can now be entered in EMR using “.SICGCOVID” Template.
<table>
<thead>
<tr>
<th>Serious Illness Conversation Guide</th>
<th>Serious Illness Conversation Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONVERSATION FLOW</strong></td>
<td><strong>PATIENT-TESTED LANGUAGE</strong></td>
</tr>
</tbody>
</table>
| 1. **Set up the conversation**   | "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?"
| Introduce purpose                | "What is your understanding now of where you are with your illness?"
| Prepare for future decisions     | "How much information about what is likely to be ahead with your illness would you like from me?"
| Ask permission                   | "I want to share with you my understanding of where things are with your illness..."
| 2. **Assess understanding and preferences** | **Uncertain:** "It can be difficult to predict what will happen with your illness. 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."
| 3. **Share prognosis**           | **OR**
| Share prognosis                  | "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)."
| Frame as a ‘wish...worry’, ‘hope...worry’ statement | **OR**
| Allow silence, explore emotion   | "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**        | "What are your most important goals if your health situation worsens?"
| Goals                            | "What are your biggest fears and worries about the future with your health?"
| Fears and worries                 | "What gives you strength as you think about the future with your illness?"
| Sources of strength              | "What abilities are so critical to your life that you can’t imagine living without them?"
| Critical abilities               | "If you become sick, how much are you willing to go through for the possibility of gaining more time?"
| Tradeoffs                        | "How much does your family know about your priorities and wishes?"
| Family                           | "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."
| 5. **Close the conversation**    | "How does this plan seem to you?"
| Summarize                        | "I want to close the conversation. Let’s review the key points we’ve discussed today."
| Make a recommendation            | "I want to provide you with a summary of what we’ve discussed today."
| Check in with patient            | "I want to ensure that you understand the information we’ve covered."
| Affirm commitment                | "I want to make sure that you feel comfortable with the decisions we’ve made together."
| 6. **Document your conversation**| "I want to document the conversation for your medical record."
| 7. **Communicate with key clinicians** | "I want to communicate with your key clinicians about the decisions we’ve made together."

"I want to close the conversation. Let’s review the key points we’ve discussed today."
"I want to provide you with a summary of what we’ve discussed today."
"I want to ensure that you understand the information we’ve covered.
"I want to make sure that you feel comfortable with the decisions we’ve made together."
"I want to document the conversation for your medical record."
"I want to communicate with your key clinicians about the decisions we’ve made together."
Serious Illness Conversation Guide

Conversation was held with patient:
- power of attorney
- spouse
- son
- daughter
- brother
- sister
- significant other
- other

> Comments

Patient understanding of illness:
What is your understanding now of where you are with your illness?
- appropriate
- poor
- overestimates survival
- underestimates survival

> Comments

Information sharing preferences:
- wants to be fully informed
- does not want bad news
- wants the big picture without details
- wants information shared with someone else
- wants no information

> Comments

Prognosis shared with patient:
I want to share with you my understanding of where things are with your illness.

- durable
- not durable
- uncertain
- continued decline
- a few years survival
- months-to-years survival
- weeks-to-months survival
- days-to-weeks survival

> Comments

Patient emotions observed or reported:
- denial
- anger
- bargaining
- sadness
- anxiety
- fearfulness
- acceptance

> Comments

Patient goals:
What are your most important goals if your health situation worsens?
- achieving an important life goal
- being mentally aware
- providing support for family
- being at home
- being comfortable
- living as long as possible
- being independent

> Comments

Patient fears and worries:
What are your biggest fears and worries about the future with your health?
- pain
- physical suffering
- inability to care for others
- loss of control
- finances
- being a burden
- family concerns
- emotional concerns

> Comments

Sources of strength:
Advance Care Planning

Comments

- Patient fears and worries

What are your biggest fears and worries about the future with your health?

- pain
- physical suffering
- inability to care for others
- loss of control
- finances
- being a burden
- family concerns
- emotional concerns
- concerns about life meaning
- spiritual distress
- loss of dignity
- preparing for death
- getting unwanted treatments

- Comments

Sources of strength

What gives you strength as you think about the future of your illness?

- family
- friends or community
- religious faith
- not discussed

- Comments

Critical abilities

What abilities are so critical to your life that you can’t imagine living without them? Or, what makes life meaningful?

- being conscious of surroundings
- communicating with others
- being able to care for oneself
- living independently
- not discussed

- Comments

Trade-offs

If you become sicker, how much are you willing to go through for the possibility of gaining more time?

- being on a ventilator
- being in the ICU
- living in a nursing home
- undergoing invasive procedures
- enduring physical discomfort
- enduring severe pain
- having artificial nutrition
- not discussed

- Comments

Family understanding

How much does your family know about your priorities and wishes?

- patient does not want family informed
- patient has not discussed with family
- patient has had some incomplete discussions with family
- patient has had extensive discussions with family
- patient plans to discuss with family independently
- patient wants help discussing with family
- patient wants clinician to discuss with family

- Comments

Recommendations

I recommend that we do the following to make sure your treatment plans reflect what’s important to you. How does this plan seem to you?

- additional conversation with physician
- conversation with family
- advance directive
- POLST or MOLST
- second opinion
- referral to pastoral care
- referral to social work
- referral to child life
- referral to palliative care
- referral to hospice
- code status change

- Comments
LaPOST

• Translates a patient’s end-of-life wishes into a physician’s order

• **Portable physician orders** - transfers with the patient across care settings

• Helps physicians, nurses, health care facilities and emergency personnel honor patient wishes regarding life-sustaining or emergency treatments

• Can be completed by the patient or the patient’s personal health care representative if the patient is unable to participate

• Neither for nor against treatment

• Complementary with advance directives
LaPOST Registry

The Louisiana LaPOST Registry is a secure, statewide electronic registry that provides a single source of truth for LaPOST and advance care planning documentation. It is instantly accessible online to authorized health care professionals in any care setting.
LaPOST Registry Solution
Statewide Electronic End-of-Life Medical Orders Registry
Epic Integrated LaPOST Registry – Key Benefits

• Offers health care providers an online tool to electronically complete and submit accurate, legally valid, error-free LaPOST forms

• Offers one-click access from Epic to a sustainable, statewide LaPOST registry network

• Provides a simple, intuitive user interface

• Provides a single source of truth for LaPOST documents

• Enhanced ACP Conversations with embedded educational resources

• Renders a printable PDF of the LaPOST form in all state-supported languages
### Advance Care Planning

#### Documents

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Status</th>
<th>Received On</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Power of Attorney</td>
<td>Received</td>
<td>10/22/20</td>
<td>HCPOA.jpg</td>
</tr>
<tr>
<td>Living Will</td>
<td>Received</td>
<td>10/22/20</td>
<td>LIVINGWILL.jpg</td>
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Jump to Document List to update filed documents

#### Filed Advance Care Planning Notes

- **Create ACP Note**
  - Date of Service: 10/05/20 16:45

#### Code Status

<table>
<thead>
<tr>
<th>Current Code Status</th>
<th>Code Status</th>
<th>Order ID</th>
<th>Comments</th>
<th>User</th>
<th>Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/22/2020 10:54</td>
<td>Full Code</td>
<td>2880983519</td>
<td></td>
<td>Physician Family Medicine, MD</td>
<td>Outpatient</td>
</tr>
</tbody>
</table>

#### LaPOST Registry (has docs on file)

**My Last Relevant Note**

There are no notes for this patient that meet the current filters.

**Family Comments**

None

**Care Team and Communications**

- **PCP**: Marlene Marie Broussard, MD
- **Type**: General
- **No referring provider set**
- **No other patient care team members**
- **Visit Treatment Team**: Kenneth J. Mans, MD
- **Relationship**: Consulting Physician
HIPPA permits disclosure of LaPOST to other health care providers as necessary.
FOR MORE INFORMATION, GO TO:
http://www.lhcqf.org/lapost-registry

EPIC PLAYGROUND PRACTICE, GO TO:
http://online.training.vyncahealth.com
Respecting Choices teaches skills to having meaningful ACP discussions

Allows providers and staff opportunities to practice and refine skills at having conversation

Respecting Choices Certification given for each completed section

Certification allows participants to use copyrighted materials that aide in the discussions
## Respecting Choices Programs

<table>
<thead>
<tr>
<th>First Steps</th>
<th>Who?</th>
<th>Where?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addresses Advance Care Planning among a healthy population, any age</td>
<td>Staff who room our patients: Nurses Medical Assistants</td>
<td>Outpatient (primary care)</td>
</tr>
<tr>
<td>-HCPOA and LW discussion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advanced Steps</th>
<th>Who?</th>
<th>Where?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addresses Advance Care Planning among a chronically ill population who <em>may</em> be in their last 1-2 years of life</td>
<td>MD/APP Nurses Social Workers Chaplain</td>
<td>Outpatient Inpatient</td>
</tr>
<tr>
<td>-LaPOST discussion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SDMSI – Shared Decision Making in Serious Illness</th>
<th>Who?</th>
<th>Where?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addresses shared decision making with family, caregivers, &amp; patients in times where a patient is <strong>CURRENTLY</strong> facing difficult treatment choices</td>
<td>MD/APP</td>
<td>Inpatient Outpatient</td>
</tr>
</tbody>
</table>
# Length of Class & Required Pre-Work

<table>
<thead>
<tr>
<th></th>
<th>First Steps</th>
<th>Advanced Steps</th>
<th>SDMSI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class time</strong></td>
<td>Full day</td>
<td>Full day</td>
<td>Half day</td>
</tr>
<tr>
<td><strong>Pre-work</strong></td>
<td>Online modules (4) assigned by Respecting Choices</td>
<td>Online modules (6) assigned by Respecting Choices</td>
<td>none</td>
</tr>
</tbody>
</table>
Respecting Choices

To register for Respecting Choices classes:

• Contact Kori DiGiovanni at kori.digiovanni@ochsner.org

• Send email to palliativemedicine@ochsner.org
Resources for Advance Care Planning & Spiritual Care
Louisiana Physician For Scope Of Treatment LaPOST

• www.La-POST.org

• Webpage has section “What My Cultural /Religious Heritage Tells Me About End Of Life Care”

• Can Consult Chaplin Services For Anyone Having Difficulty With EOL Decisions And Their Spirituality
The Center to Advance Palliative Care

The Center to Advance Palliative Care (CAPC), established in 1999, is a national organization dedicated to increasing the availability of quality health care for people living with a serious illness. As the nation's leading resource in its field, CAPC provides health care professionals and organizations with the training, tools, and technical assistance necessary to effectively redesign care systems that meet this need. CAPC is funded through organizational membership and the generous support of foundations and private philanthropy. It is part of the Icahn School of Medicine at Mount Sinai, in New York City. Visit capc.org.
Creating a CAPC User Account

Welcome to the Center to Advance Palliative Care

How to Create a CAPC User Account

Creating an Account
1. Visit [CAPC.org](https://www.capc.org) and click “Create Account” in the upper right corner.

2. Select your “Organization” from the dropdown list of the organizations – you can start typing it in.

Member Registration
If your organization is a CAPC member, you can create a member user account for free access to all member resources. Select your organization to create your own user account.

3. Enter your work email address, create a password, answer all questions, and agree to the terms.

4. Check your email inbox for a verification email from noreply@capc.org and click the link provided to finalize set-up. If the email does not show in your work inbox, please check junk/spam folder.

Accessing the CAPC Website
5. Click “Login” in the upper right corner on [CAPC.org](https://www.capc.org) on all subsequent visits. Or, wherever you encounter members-only content (identified with a lock icon) click “Login”.

For assistance setting up your account or accessing courses, contact membership@capc.org

6. A four-minute video tour of the new website, showing where all the different resources lie, can be found by visiting: [https://media.capc.org/how-to-video/capc-how-to-2019-03.mp4](https://media.capc.org/how-to-video/capc-how-to-2019-03.mp4)

For assistance with content, please email membershiprelations@capc.org
Online Clinical Training Courses For All Clinicians

All specialties and disciplines can strengthen their care of patients living with a serious illness.

For CAPC members, CAPC’s online training curriculum provides free continuing education credits for physicians, nurses, social workers, case managers, and licensed professional counselors at member organizations. Free ABIM MOC (Maintenance of Certification) points are also available for physicians. Download a course catalog with information about continuing education credits and ABIM MOC points for all CAPC courses. Download an overview of CAPC continuing education mission and policy to learn more.

CAPC Designation status is available for clinicians who complete the following units: Communication Skills, Pain Management, Symptom Management, and Best Practices in Dementia Care.
Palliative Care Referral Process
PLACING A REFERRAL TO PALLIATIVE CARE OUTPATIENT CLINICS

1. Enter referral order – Ambulatory referral/consult to Palliative Care

   - **Order Information**
     - Procedure: Ambulatory referral/consult to Palliative Care
     - Proc Category: Outpatient Referral Orderables

   - **Class:** Internal Referral

2. Select class “Internal”

3. Enter comments
   - Patient aware of the referral: Yes
   - Symptom Management: Symptom Management and staged PH
   - Goals of Care: Coping with Life-Limiting Illness
   - Does patient have more than two hospitalizations in the past month for the same problem? No

4. Select region where outpatient care is requested — St. Tammany

   - **Order Specific Questions**
     - **Reason:** Referred to Region
       - Only select requests you would like the patient. New Orleans may
     - **Comment:** be seen in 3.5 to 4.5 is outside of the current insurance’s department.
Referring providers can currently only choose 1 reason for the Palliative Care referral. They can add additional reasons in the “comments” section.
Final Thoughts
Final Thoughts…

Advance care planning decisions can be a gift of love from patients to their families. Caregivers will not have to wonder, “Should I have decide this instead of that…” or “Did I make the right decision?” or “Is that what they would have wanted?”. The decisions they have to make in those moments, when advance care planning was never discussed, will stay with them a lifetime.
Final Thoughts…

Advance care planning should not be a single discussion, but an ongoing conversation throughout the continuum of someone’s life…

Coordinated, collaborative advance care planning affords STHS the opportunity to provide the right care, to the right patient, at the right time, every time.
Thank you!

emonies@stph.org
(985)871-5975