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?

MOST ADVANCE DIRECTIVES

Comfort Care Only

Aggressive

NARRATIVE DIRECTIVE

Values

Goals

Quality of life

Life history

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.

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

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.

The Kind of Medical Treatment I Want or Do Not Want

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

LOUISIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (LaPOST)

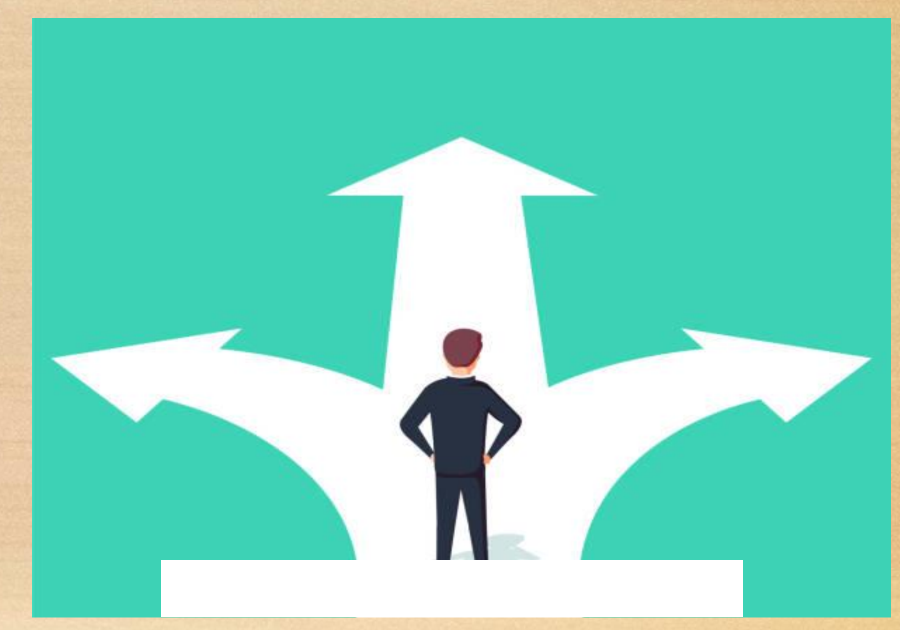
Hierarchy of Medical Decision-Making

Louisiana's Legal Hierarchy of Medical Decision-Making

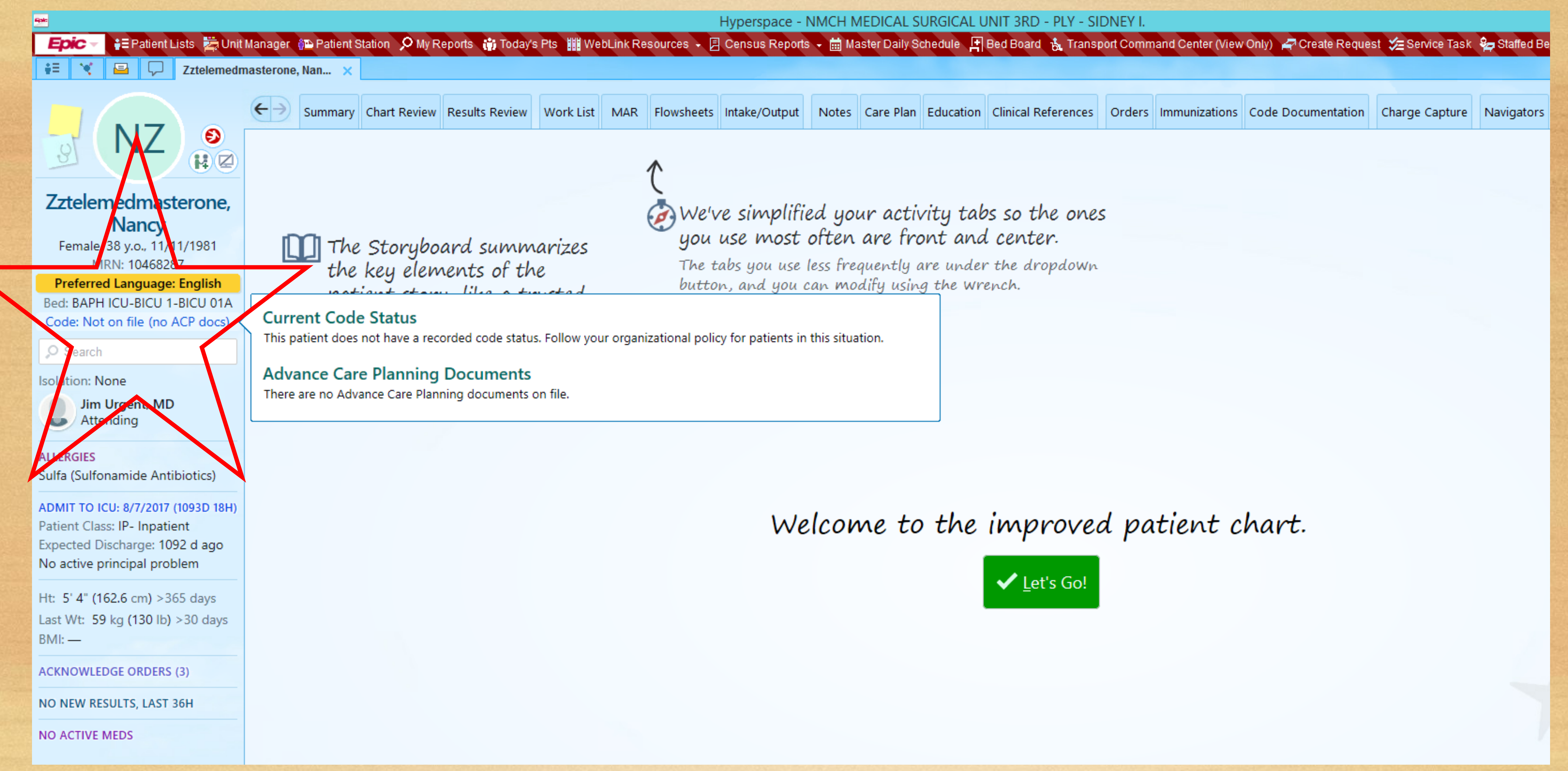
Every state has laws that govern who can make medical decisions for a patient in the event he becomes unable to make medical decisions for himself. The following is the hierarchy of medical decision makers in Louisiana:

- 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)

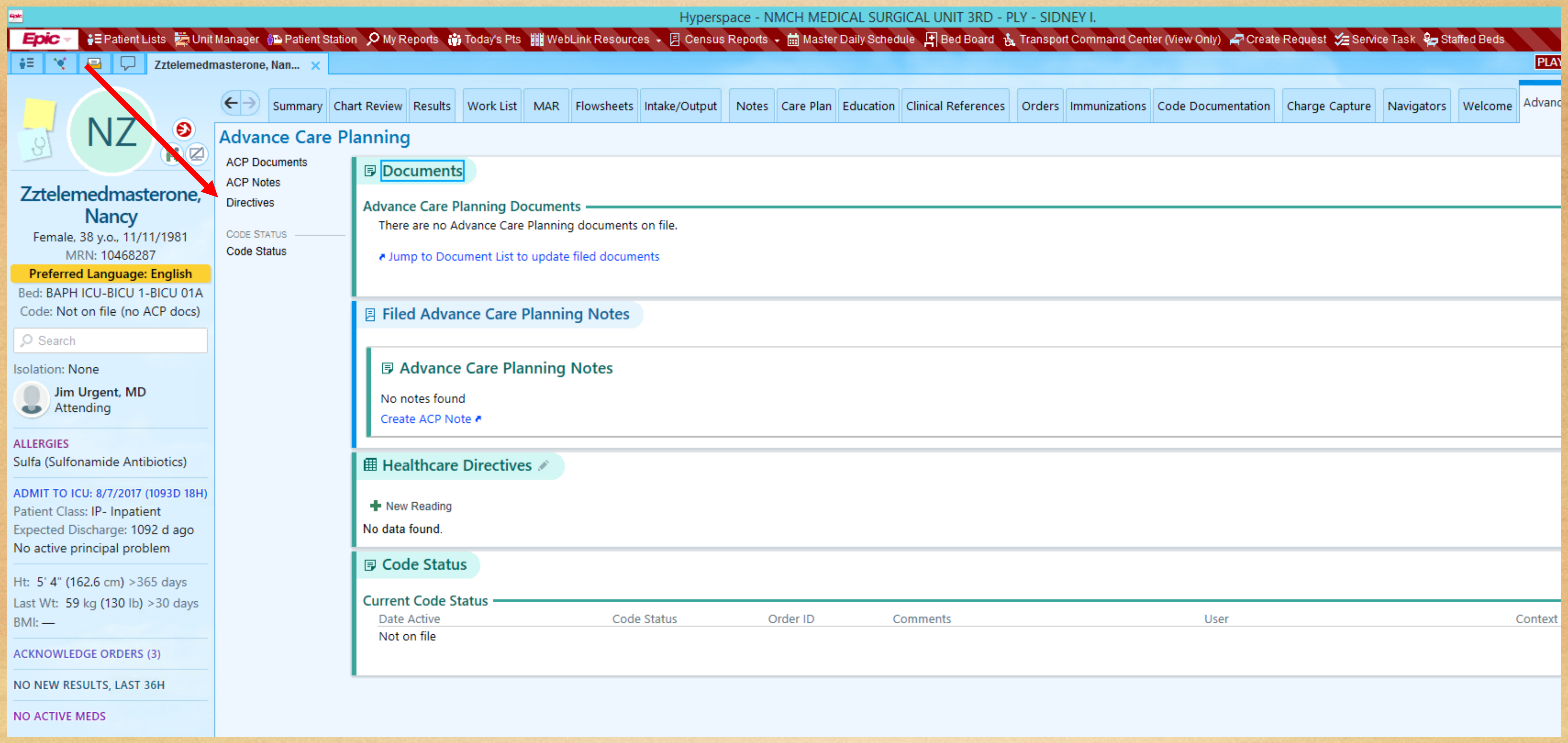
Source: Koppel, A., JD, Sullivan, S., JD. Legal Considerations in End of Life Decision-Making in Louisiana. The Ochsner Journal, v.11(4); Winter, 2011.



Checking ACP in EPIC during hospital admission



Hyperspace - NMCH MEDICAL SURGICAL UNIT 3RD - PLY - SIDNEY I.
Epic
Patient Lists
Unit Manager
Patient Station
My Reports
Today's Pts
WebLink Resources
Census Reports
Master Daily Schedule
Bed Board
Transport Command Center (View Only)
Create Request
Service Task
Zztelemedmasterone, Nan...
Summary
Chart Review
Results Review
Work List
MAR
Flowsheets
Intake/Output
Notes
Care Plan
Education
Clinical References
Orders
Immunizations
Code Documentation
Charge Capture
Navigators
NZ
Zztelemedmasterone, Nancy
Female, 38 y.o., 11/11/1981
MRN: 10468287
Preferred Language: English
Bed: BAPH ICU-BICU 1-BICU 01A
Code: Not on file (no ACP docs)
Search
Isolation: None
Jim Urgent, MD
Attending
ALLERGIES
Sulfa (Sulfonamide Antibiotics)
ADMIT TO ICU: 8/7/2017 (1093D 18H)
Patient Class: IP- Inpatient
Expected Discharge: 1092 d ago
No active principal problem
Ht: 5' 4" (162.6 cm) >365 days
Last Wt: 59 kg (130 lb) >30 days
BMI: —
ACKNOWLEDGE ORDERS (3)
NO NEW RESULTS, LAST 36H
NO ACTIVE MEDS
The Storyboard summarizes the key elements of the
We've simplified your activity tabs so the ones you use most often are front and center.
The tabs you use less frequently are under the dropdown button, and you can modify using the wrench.
Current Code Status
This patient does not have a recorded code status. Follow your organizational policy for patients in this situation.
Advance Care Planning Documents
There are no Advance Care Planning documents on file.
Welcome to the improved patient chart.
Let's Go!



Hyperspace - NMCH MEDICAL SURGICAL UNIT 3RD - PLY - SIDNEY I.
Epic
Patient Lists
Unit Manager
Patient Station
My Reports
Today's Pts
WebLink Resources
Census Reports
Master Daily Schedule
Bed Board
Transport Command Center (View Only)
Create Request
Service Task
Staffed Beds
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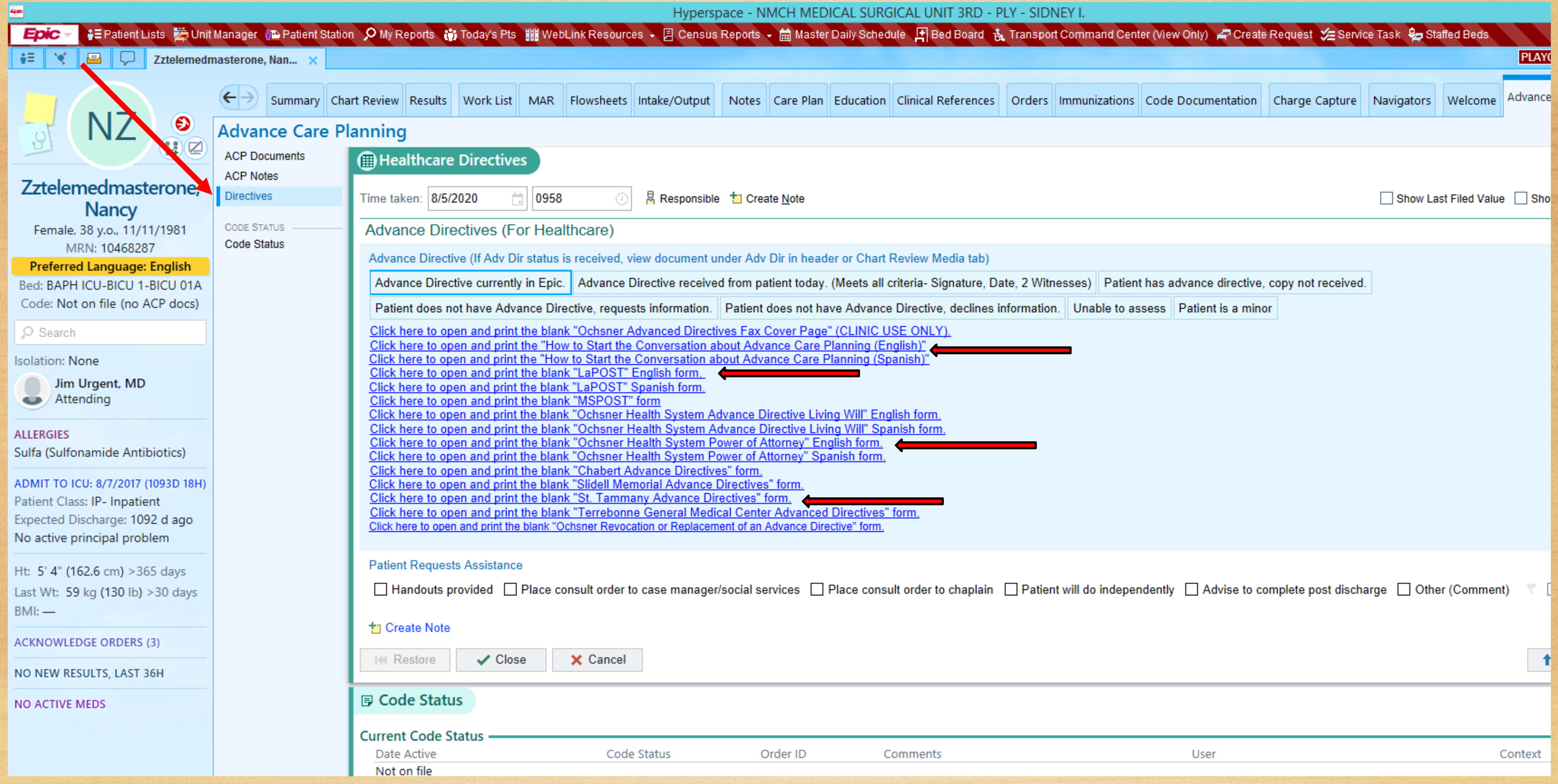
ACKNOWLEDGE ORDERS (3)
NO NEW RESULTS, LAST 36H
NO ACTIVE MEDS
Advance Care Planning
ACP Documents
ACP Notes
Directives
CODE STATUS
Code Status
Documents
Advance Care Planning Documents
There are no Advance Care Planning documents on file.
Jump to Document List to update filed documents
Filed Advance Care Planning Notes
Advance Care Planning Notes
No notes found
Create ACP Note
Healthcare Directives
New Reading
No data found.
Code Status
Current Code Status
Date Active
Code Status
Order ID
Comments
User
Context
Not on file



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BMI: —
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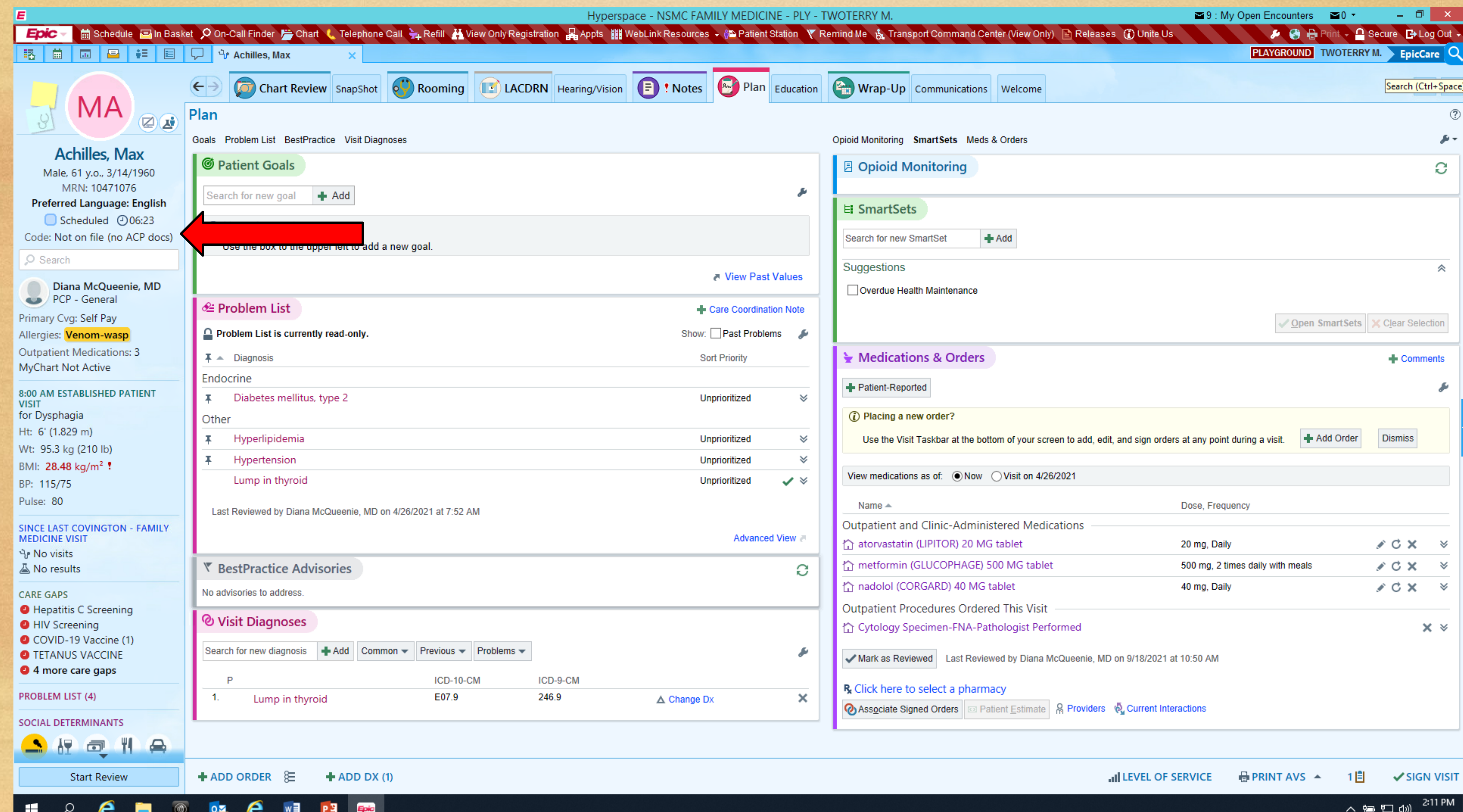
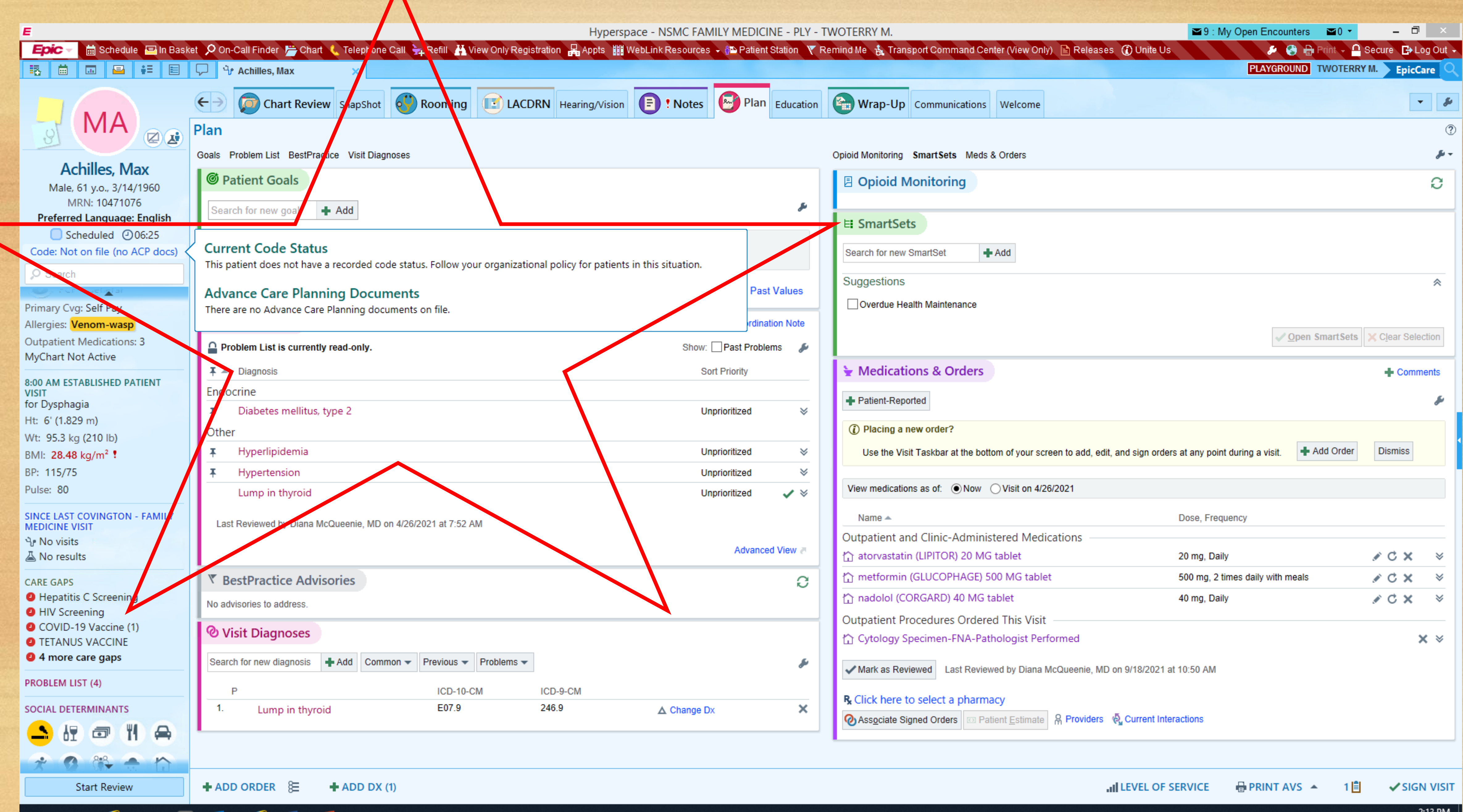
NO ACTIVE MEDS
Advance Care Planning
ACP Documents
ACP Notes
Directives
CODE STATUS
Code Status
Healthcare Directives
Time taken: 8/5/2020 0958
Responsible
Create Note
Show Last Filed Value
Advance Directives (For Healthcare)
Advance Directive (If Adv Dir status is received, view document under Adv Dir in header or Chart Review Media tab)
Advance Directive currently in Epic.
Advance Directive received from patient today. (Meets all criteria- Signature, Date, 2 Witnesses)
Patient has advance directive, copy not received.
Patient does not have Advance Directive, requests information.
Patient does not have Advance Directive, declines information.
Unable to assess
Patient is a minor
Click here to open and print the blank "Ochsner Advanced Directives Fax Cover Page" (CLINIC USE ONLY).
Click here to open and print the "How to Start the Conversation about Advance Care Planning (English)"
Click here to open and print the "How to Start the Conversation about Advance Care Planning (Spanish)"
Click here to open and print the blank "LaPOST" English form.
Click here to open and print the blank "LaPOST" Spanish form.
Click here to open and print the blank "MSPOST" form
Click here to open and print the blank "Ochsner Health System Advance Directive Living Will" English form.
Click here to open and print the blank "Ochsner Health System Advance Directive Living Will" Spanish form.
Click here to open and print the blank "Ochsner Health System Power of Attorney" English form.
Click here to open and print the blank "Ochsner Health System Power of Attorney" Spanish form.
Click here to open and print the blank "Chabert Advance Directives" form.
Click here to open and print the blank "Slidell Memorial Advance Directives" form.
Click here to open and print the blank "St. Tammany Advance Directives" form.
Click here to open and print the blank "Terrebonne General Medical Center Advanced Directives" form.
Click here to open and print the blank "Ochsner Revocation or Replacement of an Advance Directive" form.
Patient Requests Assistance
Handouts provided
Place consult order to case manager/social services
Place consult order to chaplain
Patient will do independently
Advise to complete post discharge
Other (Comment)
Create Note
Restore
Close
Cancel
Code Status
Current Code Status
Date Active
Code Status
Order ID
Comments
User
Context
Not on file

Checking ACP in EPIC during clinic visit


Hyperspace - NSMC FAMILY MEDICINE - PLY - TWOTERRY M.
9 : My Open Encounters
Epic
Schedule
In Basket
On-Call Finder
Chart
Telephone Call
Refill
View Only Registration
Appts
WebLink Resources
Patient Station
Remind Me
Transport Command Center (View Only)
Releases
Unite Us
Print
Secure
Log Out
Achilles, Max
PLAYGROUND
TWOTERRY M.
EpicCare
MA
Achilles, Max
Male, 61 y.o., 3/14/1960
MRN: 10471076
Preferred Language: English
Scheduled 06:23
Code: Not on file (no ACP docs)
Search
Diana McQueenie, MD
PCP - General
Primary Cvg: Self Pay
Allergies: Venom-wasp
Outpatient Medications: 3
MyChart Not Active
8:00 AM ESTABLISHED PATIENT VISIT
for Dysphagia
Ht: 6' (1.829 m)
Wt: 95.3 kg (210 lb)
BMI: 28.48 kg/m²
BP: 115/75
Pulse: 80
SINCE LAST COVINGTON - FAMILY MEDICINE VISIT
No visits
No results
CARE GAPS
Hepatitis C Screening
HIV Screening
COVID-19 Vaccine (1)
TETANUS VACCINE
4 more care gaps
PROBLEM LIST (4)
SOCIAL DETERMINANTS
Start Review
Chart Review
SnapShot
Rooming
LACDRN
Hearing/Vision
Notes
Plan
Education
Wrap-Up
Communications
Welcome
Search (Ctrl+Space)
Plan
Goals
Problem List
BestPractice
Visit Diagnoses
Opioid Monitoring
SmartSets
Meds & Orders
Patient Goals
Search for new goal
Add
Use the box to the upper left to add a new goal.
View Past Values
Problem List
Care Coordination Note
Problem List is currently read-only.
Show: Past Problems
Diagnosis
Sort Priority
Endocrine
Diabetes mellitus, type 2
Unprioritized
Other
Hyperlipidemia
Unprioritized
Hypertension
Unprioritized
Lump in thyroid
Unprioritized
Last Reviewed by Diana McQueenie, MD on 4/26/2021 at 7:52 AM
Advanced View
BestPractice Advisories
No advisories to address.
Visit Diagnoses
Search for new diagnosis
Add
Common
Previous
Problems
P
ICD-10-CM
ICD-9-CM
1.
Lump in thyroid
E07.9
246.9
Change Dx
Opioid Monitoring
SmartSets
Search for new SmartSet
Add
Suggestions
Overdue Health Maintenance
Open SmartSets
Clear Selection
Medications & Orders
Comments
Patient-Reported
Placing a new order?
Use the Visit Taskbar at the bottom of your screen to add, edit, and sign orders at any point during a visit.
Add Order
Dismiss
View medications as of:
Now
Visit on 4/26/2021
Name
Dose, Frequency
Outpatient and Clinic-Administered Medications
atorvastatin (LIPITOR) 20 MG tablet
20 mg, Daily
metformin (GLUCOPHAGE) 500 MG tablet
500 mg, 2 times daily with meals
nadolol (CORGARD) 40 MG tablet
40 mg, Daily
Outpatient Procedures Ordered This Visit
Cytology Specimen-FNA-Pathologist Performed
Mark as Reviewed
Last Reviewed by Diana McQueenie, MD on 9/18/2021 at 10:50 AM
Click here to select a pharmacy
Associate Signed Orders
Patient Estimate
Providers
Current Interactions
ADD ORDER
ADD DX (1)
LEVEL OF SERVICE
PRINT AVS
SIGN VISIT
2:11 PM
4/26/2021



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Remind Me
Transport Command Center (View Only)
Releases
Unite Us
Print
Secure
Log Out
Achilles, Max
PLAYGROUND
TWOTERRY M.
EpicCare
MA
Achilles, Max
Male, 61 y.o., 3/14/1960
MRN: 10471076
Preferred Language: English
Scheduled 06:25
Code: Not on file (no ACP docs)
Search
Primary Cvg: Self Pay
Allergies: Venom-wasp
Outpatient Medications: 3
MyChart Not Active
8:00 AM ESTABLISHED PATIENT VISIT
for Dysphagia
Ht: 6' (1.829 m)
Wt: 95.3 kg (210 lb)
BMI: 28.48 kg/m²
BP: 115/75
Pulse: 80
SINCE LAST COVINGTON - FAMILY MEDICINE VISIT
No visits
No results
CARE GAPS
Hepatitis C Screening
HIV Screening
COVID-19 Vaccine (1)
TETANUS VACCINE
4 more care gaps
PROBLEM LIST (4)
SOCIAL DETERMINANTS
Start Review
Chart Review
SnapShot
Rooming
LACDRN
Hearing/Vision
Notes
Plan
Education
Wrap-Up
Communications
Welcome
Plan
Goals
Problem List
BestPractice
Visit Diagnoses
Patient Goals
Search for new goal
Add
Current Code Status
This patient does not have a recorded code status. Follow your organizational policy for patients in this situation.
Advance Care Planning Documents
There are no Advance Care Planning documents on file.
Past Values
rdination Note
Problem List is currently read-only.
Show: Past Problems
Diagnosis
Sort Priority
Endocrine
Diabetes mellitus, type 2
Unprioritized
Other
Hyperlipidemia
Unprioritized
Hypertension
Unprioritized
Lump in thyroid
Unprioritized
Last Reviewed by Diana McQueenie, MD on 4/26/2021 at 7:52 AM
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No advisories to address.
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Search for new diagnosis
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ICD-10-CM
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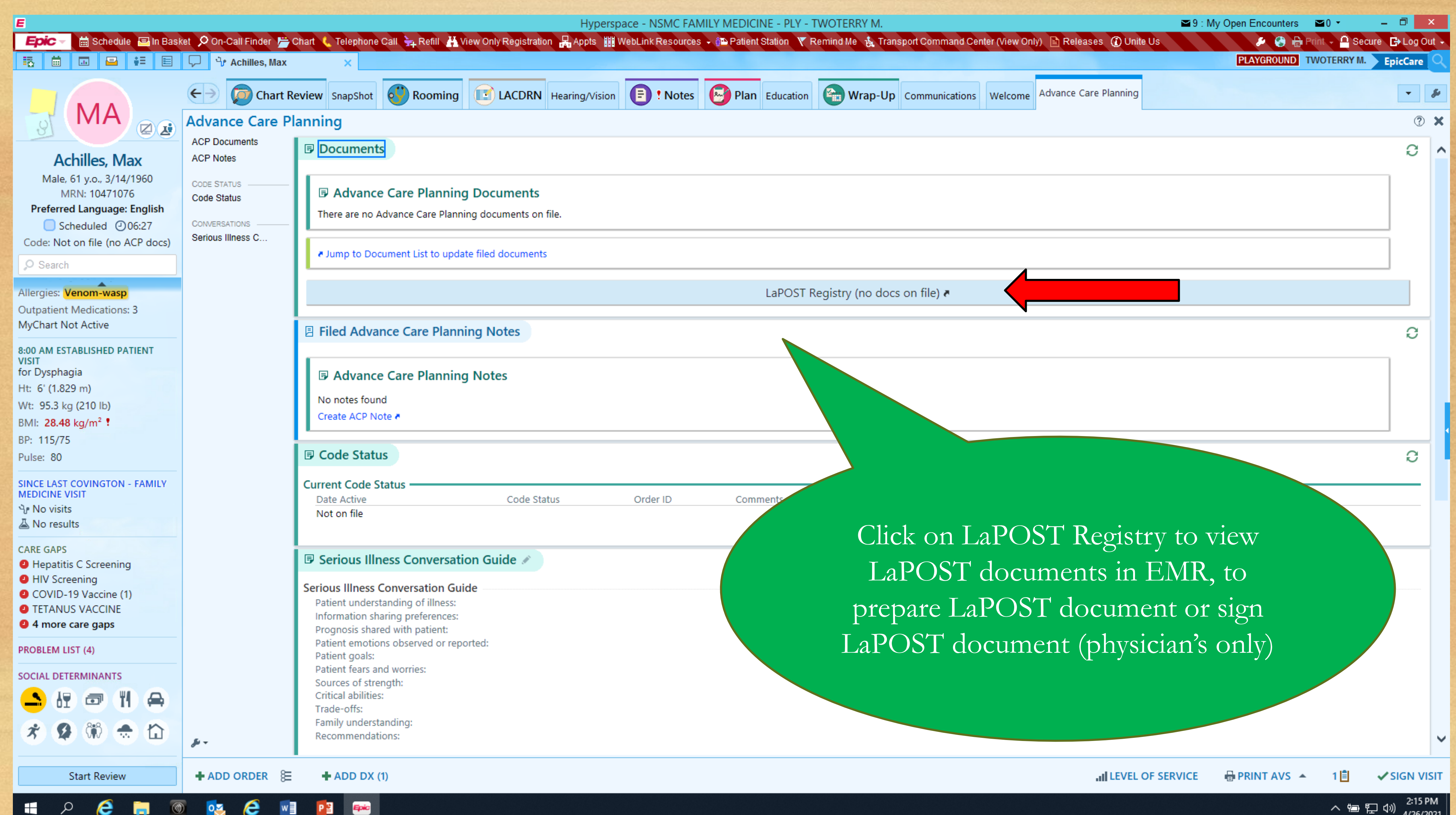
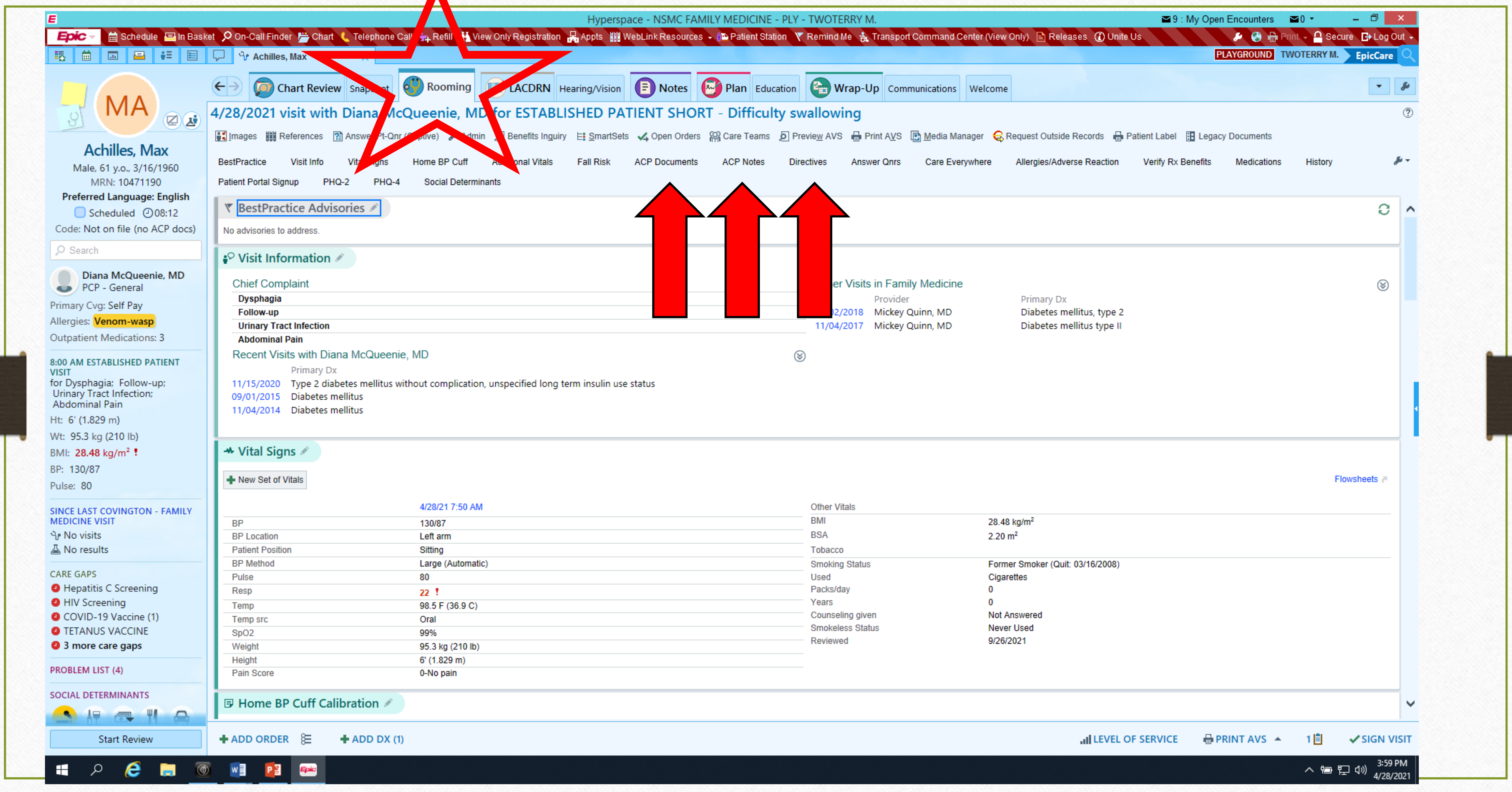
Lump in thyroid
E07.9
246.9
Change Dx
Opioid Monitoring
SmartSets
Meds & Orders
Opioid Monitoring
SmartSets
Search for new SmartSet
Add
Suggestions
Overdue Health Maintenance
Open SmartSets
Clear Selection
Medications & Orders
Comments
Patient-Reported
Placing a new order?
Use the Visit Taskbar at the bottom of your screen to add, edit, and sign orders at any point during a visit.
Add Order
Dismiss
View medications as of: Now Visit on 4/26/2021
Name
Dose, Frequency
Outpatient and Clinic-Administered Medications
atorvastatin (LIPITOR) 20 MG tablet
20 mg, Daily
metformin (GLUCOPHAGE) 500 MG tablet
500 mg, 2 times daily with meals
nadolol (CORGARD) 40 MG tablet
40 mg, Daily
Outpatient Procedures Ordered This Visit
Cytology Specimen-FNA-Pathologist Performed
Mark as Reviewed
Last Reviewed by Diana McQueenie, MD on 9/18/2021 at 10:50 AM
Click here to select a pharmacy
Associate Signed Orders
Patient Estimate
Providers
Current Interactions
ADD ORDER
ADD DX (1)
LEVEL OF SERVICE
PRINT AVS
SIGN VISIT
2:13 PM
4/26/2021


Hyperspace - NSMC FAMILY MEDICINE - PLY - TWOTERRY M.
Achilles, Max
Male, 61 y.o., 3/14/1960
MRN: 10471076
Preferred Language: English
Code: Not on file (no ACP docs)
Advance Care Planning
ACP Documents
ACP Notes
Code Status
Serious Illness C...
Documents
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
No notes found
Create ACP Note
Code Status
Current Code Status
Date Active
Code Status
Order ID
Comments
Not on file
Serious Illness Conversation Guide
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:
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



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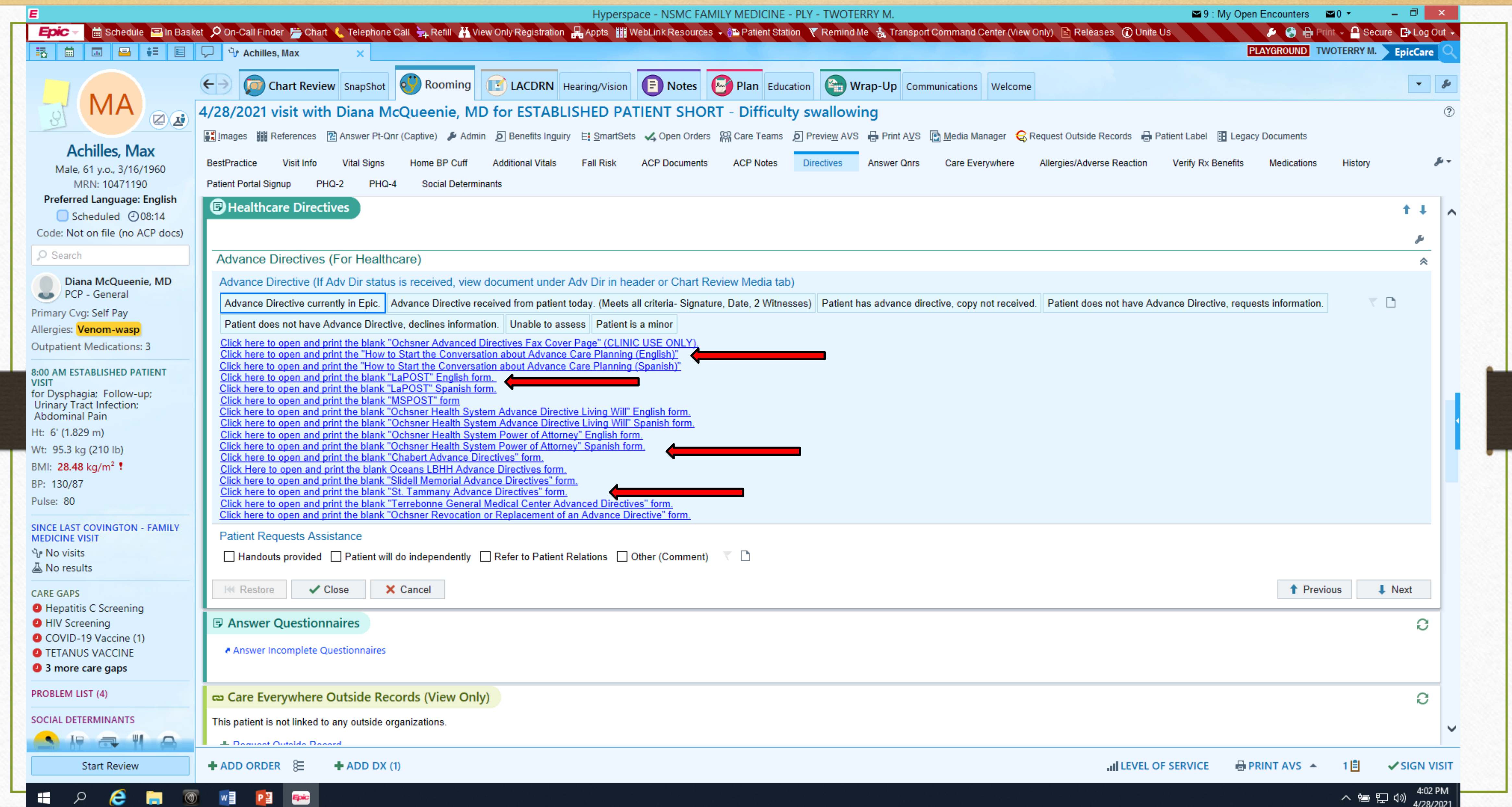
Unite Us
Print
Secure
Log Out
Achilles, Max
PLAYGROUND
TWOTERRY M.
EpicCare
MA
Achilles, Max
Male, 61 y.o., 3/16/1960
MRN: 10471190
Preferred Language: English
Scheduled 08:12
Code: Not on file (no ACP docs)
Search
Diana McQueenie, MD
PCP - General
Primary Cvg: Self Pay
Allergies: Venom-wasp
Outpatient Medications: 3
8:00 AM ESTABLISHED PATIENT VISIT
for Dysphagia; Follow-up; Urinary Tract Infection; Abdominal Pain
Ht: 6' (1.829 m)
Wt: 95.3 kg (210 lb)
BMI: 28.48 kg/m²
BP: 130/87
Pulse: 80
SINCE LAST COVINGTON - FAMILY MEDICINE VISIT
No visits
No results
CARE GAPS
Hepatitis C Screening
HIV Screening
COVID-19 Vaccine (1)
TETANUS VACCINE
3 more care gaps
PROBLEM LIST (4)
SOCIAL DETERMINANTS
Start Review
Chart Review
Rooming
LACDRN
Hearing/Vision
Notes
Plan
Education
Wrap-Up
Communications
Welcome
4/28/2021 visit with Diana McQueenie, MD for ESTABLISHED PATIENT SHORT - Difficulty swallowing
Images
References
Benefits Inquiry
SmartSets
Open Orders
Care Teams
Preview AVS
Print AVS
Media Manager
Request Outside Records
Patient Label
Legacy Documents
BestPractice
Visit Info
Home BP Cuff
Fall Risk
ACP Documents
ACP Notes
Directives
Answer Qnrs
Care Everywhere
Allergies/Adverse Reaction
Verify Rx Benefits
Medications
History
Patient Portal Signup
PHQ-2
PHQ-4
Social Determinants
BestPractice Advisories
No advisories to address.
Visit Information
Chief Complaint
Dysphagia
Follow-up
Urinary Tract Infection
Abdominal Pain
Recent Visits with Diana McQueenie, MD
Primary Dx
11/15/2020 Type 2 diabetes mellitus without complication, unspecified long term insulin use status
09/01/2015 Diabetes mellitus
11/04/2014 Diabetes mellitus
Provider
Primary Dx
Mickey Quinn, MD Diabetes mellitus, type 2
11/04/2017 Mickey Quinn, MD Diabetes mellitus type II
Vital Signs
New Set of Vitals
Flowsheets
4/28/21 7:50 AM
BP 130/87
BP Location Left arm
Patient Position Sitting
BP Method Large (Automatic)
Pulse 80
Resp 22
Temp 98.5 F (36.9 C)
Temp src Oral
SpO2 99%
Weight 95.3 kg (210 lb)
Height 6' (1.829 m)
Pain Score 0-No pain
Other Vitals
BMI 28.48 kg/m²
BSA 2.20 m²
Tobacco
Smoking Status Former Smoker (Quit: 03/16/2008)
Used Cigarettes
Packs/day 0
Years 0
Counseling given Not Answered
Smokeless Status Never Used
Reviewed 9/26/2021
Home BP Cuff Calibration
ADD ORDER
ADD DX (1)
LEVEL OF SERVICE
PRINT AVS
SIGN VISIT
3:59 PM
4/28/2021



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ACP Notes
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Answer Qnrs
Care Everywhere
Allergies/Adverse Reaction
Verify Rx Benefits
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Healthcare Directives
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Patient is a minor
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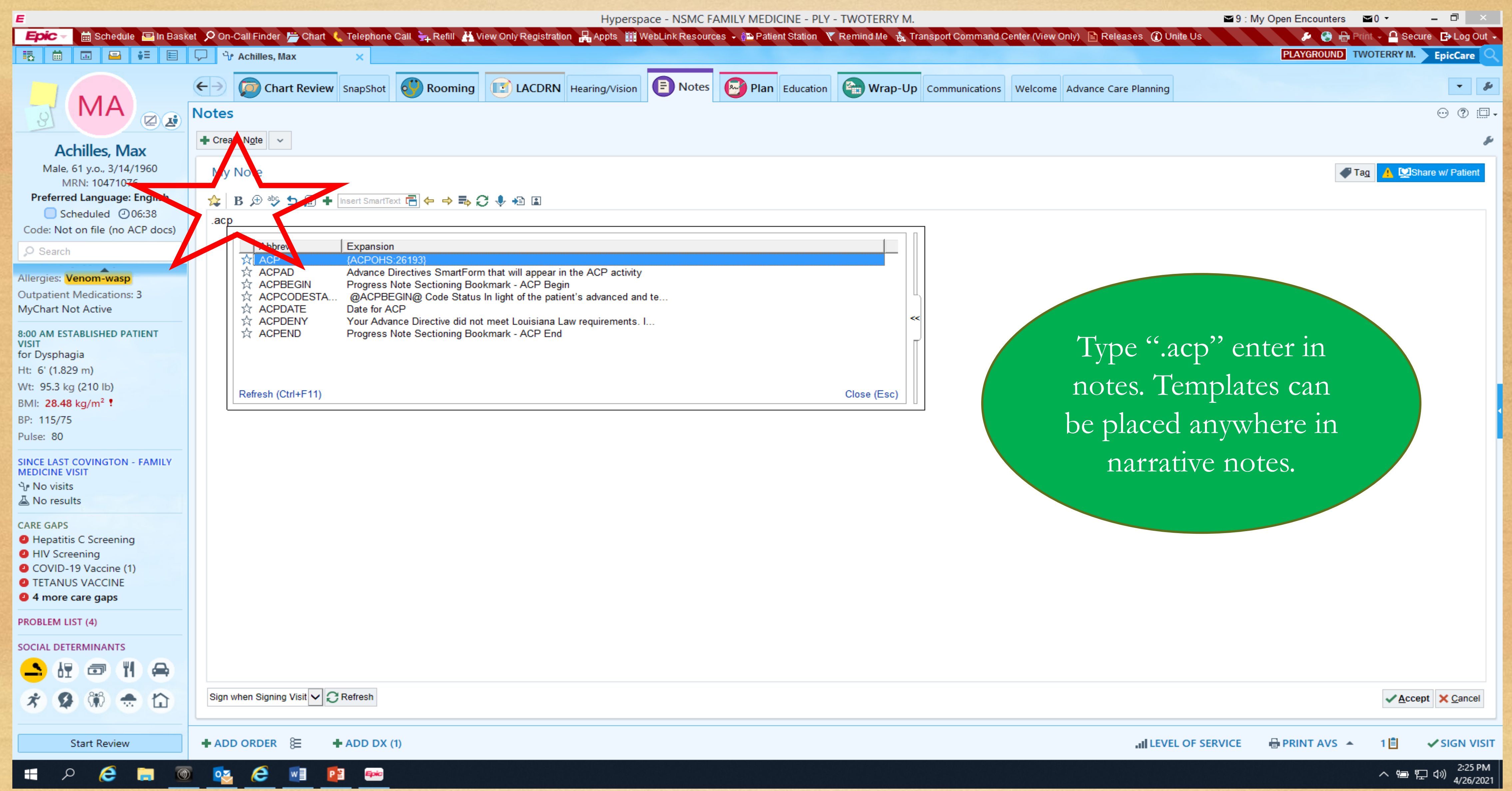
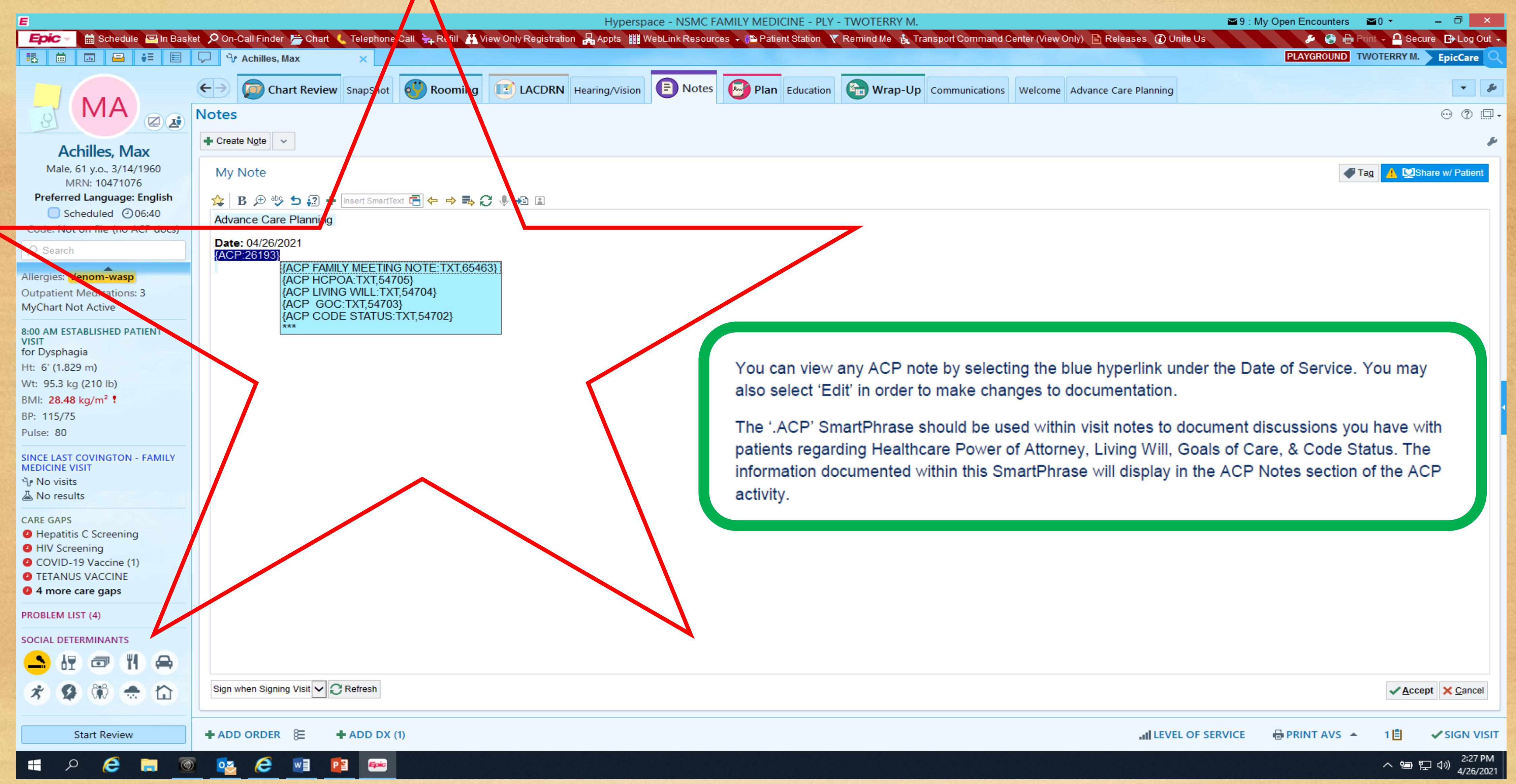
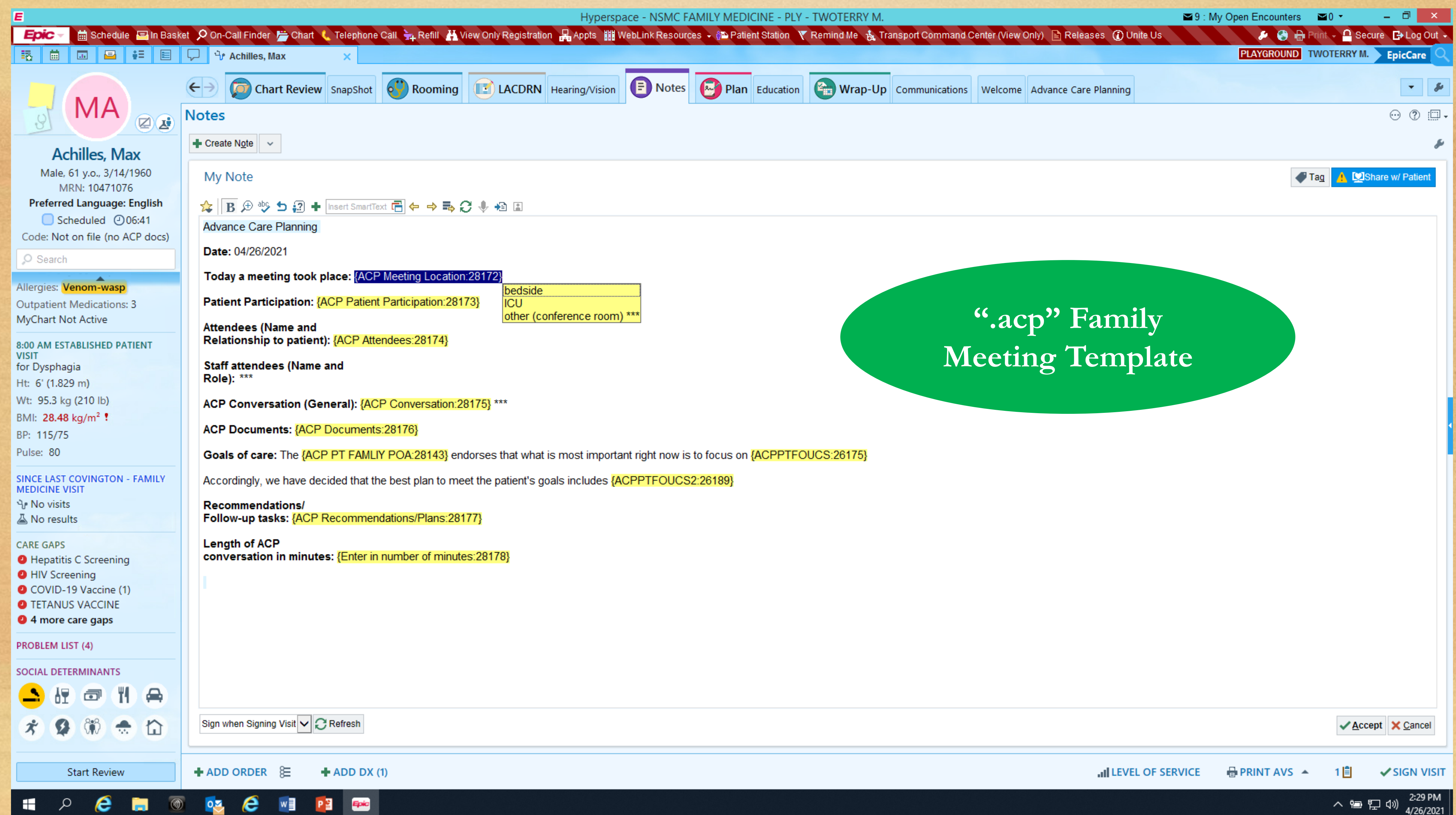
Click here to open and print the blank "Ochsner Health System Power of Attorney" Spanish form.
Click here to open and print the blank "Chabert Advance Directives" form.
Click Here to open and print the blank Oceans LBHH Advance Directives form.
Click here to open and print the blank "Slidell Memorial Advance Directives" form.
Click here to open and print the blank "St. Tammany Advance Directives" form.
Click here to open and print the blank "Terrebonne General Medical Center Advanced Directives" form.
Click here to open and print the blank "Ochsner Revocation or Replacement of an Advance Directive" form.
Patient Requests Assistance
Handouts provided
Patient will do independently
Refer to Patient Relations
Other (Comment)
Restore
Close
Cancel
Previous
Next
Answer Questionnaires
Answer Incomplete Questionnaires
Care Everywhere Outside Records (View Only)
This patient is not linked to any outside organizations.
ADD ORDER
ADD DX (1)
LEVEL OF SERVICE
PRINT AVS
SIGN VISIT

EPIC Advance Care Planning Documentation

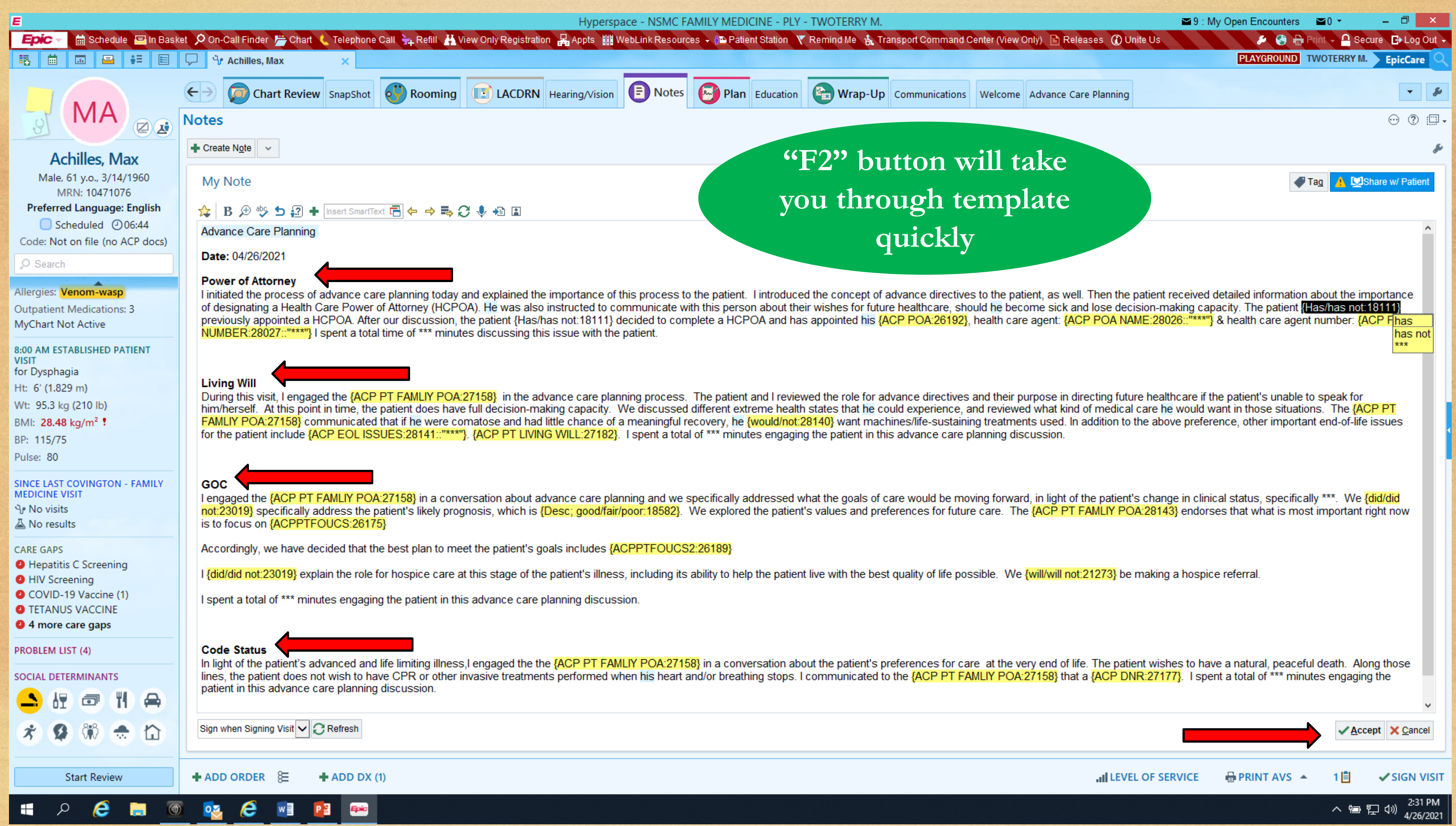


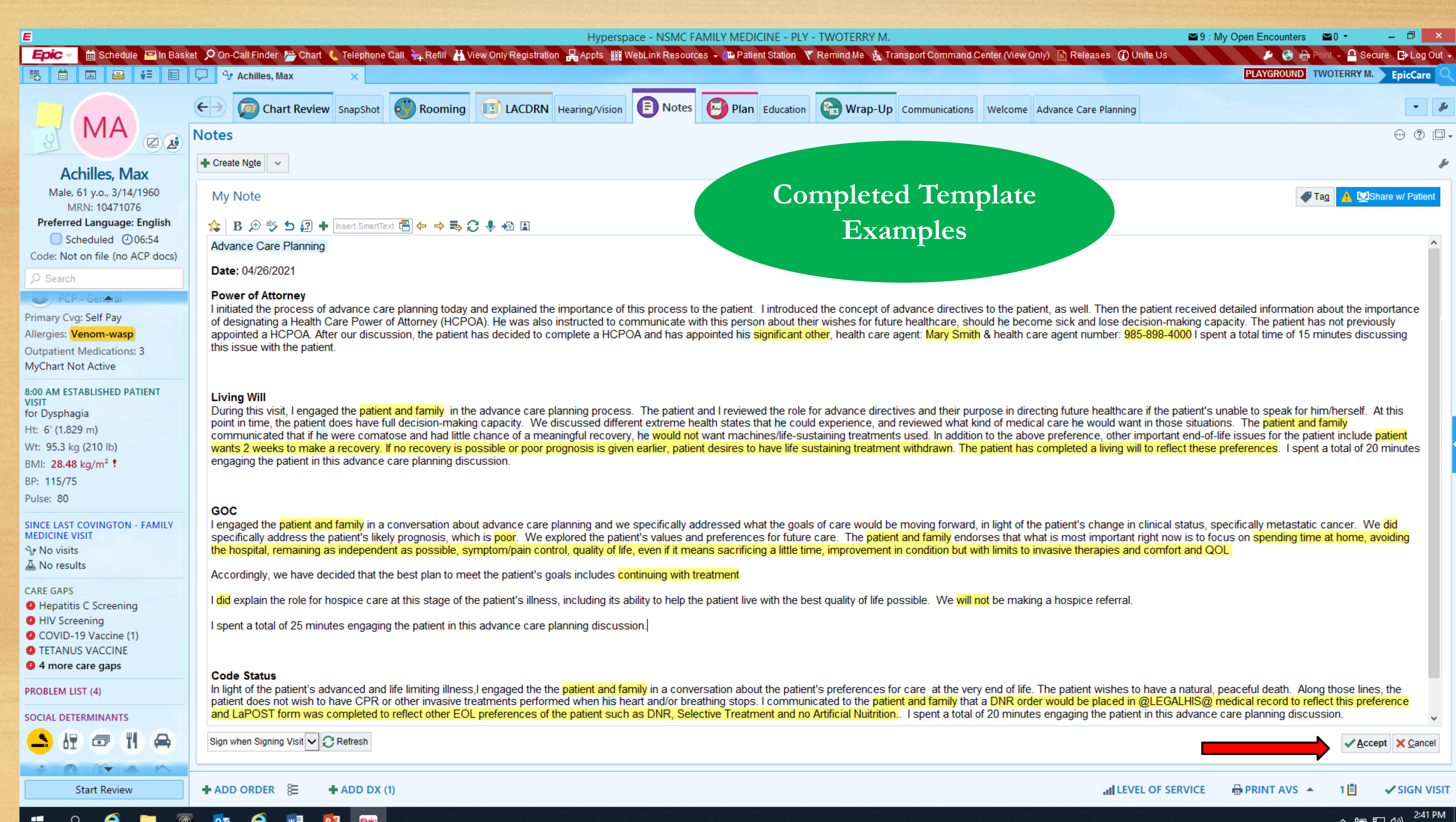
Type “.acp” enter in notes. Templates can be placed anywhere in narrative notes.
Notes
Create Note
My Note
.acp
Abbrev
Expansion
ACP
{ACPOHS:26193}
ACPAD
Advance Directives SmartForm that will appear in the ACP activity
ACPBEGIN
Progress Note Sectioning Bookmark - ACP Begin
ACPCODESTA...
@ACPBEGIN@ Code Status In light of the patient's advanced and te...
ACPDATE
Date for ACP
ACPDENY
Your Advance Directive did not meet Louisiana Law requirements. I...
ACPEND
Progress Note Sectioning Bookmark - ACP End
Refresh (Ctrl+F11)
Close (Esc)


Hyperspace - NSMC FAMILY MEDICINE - PLY - TWOTERRY M.
Achilles, Max
Notes
My Note
Advance Care Planning
Date: 04/26/2021
{ACP:26193}
{ACP FAMILY MEETING NOTE:TXT,65463}
{ACP HCPOA:TXT,54705}
{ACP LIVING WILL:TXT,54704}
{ACP GOC:TXT,54703}
{ACP CODE STATUS:TXT,54702}
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
Advance Care Planning
Date: 04/26/2021
Today a meeting took place: {ACP Meeting Location:28172}
bedside
ICU
other (conference room) ***
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}


"F2" button will take you through template quickly
Hyperspace - NSMC FAMILY MEDICINE - PLY - TWOTERRY M.
Chart Review
SnapShot
Rooming
LACDRN
Hearing/Vision
Notes
Plan
Education
Wrap-Up
Communications
Welcome
Advance Care Planning
Achilles, Max
Male, 61 y.o., 3/14/1960
MRN: 10471076
Preferred Language: English
Allergies: Venom-wasp
Notes
Create Note
My Note
Advance Care Planning
Date: 04/26/2021
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, should he become sick and lose decision-making capacity. The patient {Has/has not:18111} previously appointed a HCPOA. After our discussion, the patient {Has/has not:18111} decided to complete a HCPOA and has appointed his {ACP POA:26192}, health care agent: {ACP POA NAME:28026::"***"} & health care agent number: {ACP POA NUMBER:28027::"***"} I spent a total time of *** minutes discussing this issue with the patient.
Living Will
During this visit, I engaged the {ACP PT FAMLIY POA:27158} 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 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 {ACP PT FAMLIY POA:27158} communicated that if he were comatose and had little chance of a meaningful recovery, he {would/not:28140} want machines/life-sustaining treatments used. In addition to the above preference, other important end-of-life issues for the patient include {ACP EOL ISSUES:28141::"***"}. {ACP PT LIVING WILL:27182}. I spent a total of *** minutes engaging the patient in this advance care planning discussion.
GOC
I engaged the {ACP PT FAMLIY POA:27158} 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 ***. We {did/did not:23019} specifically address the patient's likely prognosis, which is {Desc; good/fair/poor:18582}. We explored the patient's values and preferences for future 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}
I {did/did not:23019} 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/will not:21273} be making a hospice referral.
I spent a total of *** 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 the {ACP PT FAMLIY POA:27158} 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 {ACP PT FAMLIY POA:27158} that a {ACP DNR:27177}. I spent a total of *** minutes engaging the patient in this advance care planning discussion.
Sign when Signing Visit
Refresh
Accept
Cancel
ADD ORDER
ADD DX (1)
LEVEL OF SERVICE
PRINT AVS
SIGN VISIT


Completed Template Examples
Hyperspace - NSMC FAMILY MEDICINE - PLY - TWOTERRY M.
Achilles, Max
Male, 61 y.o., 3/14/1960
MRN: 10471076
Preferred Language: English
Code: Not on file (no ACP docs)
Notes
Create Note
My Note
Advance Care Planning
Date: 04/26/2021
Power of Attorney
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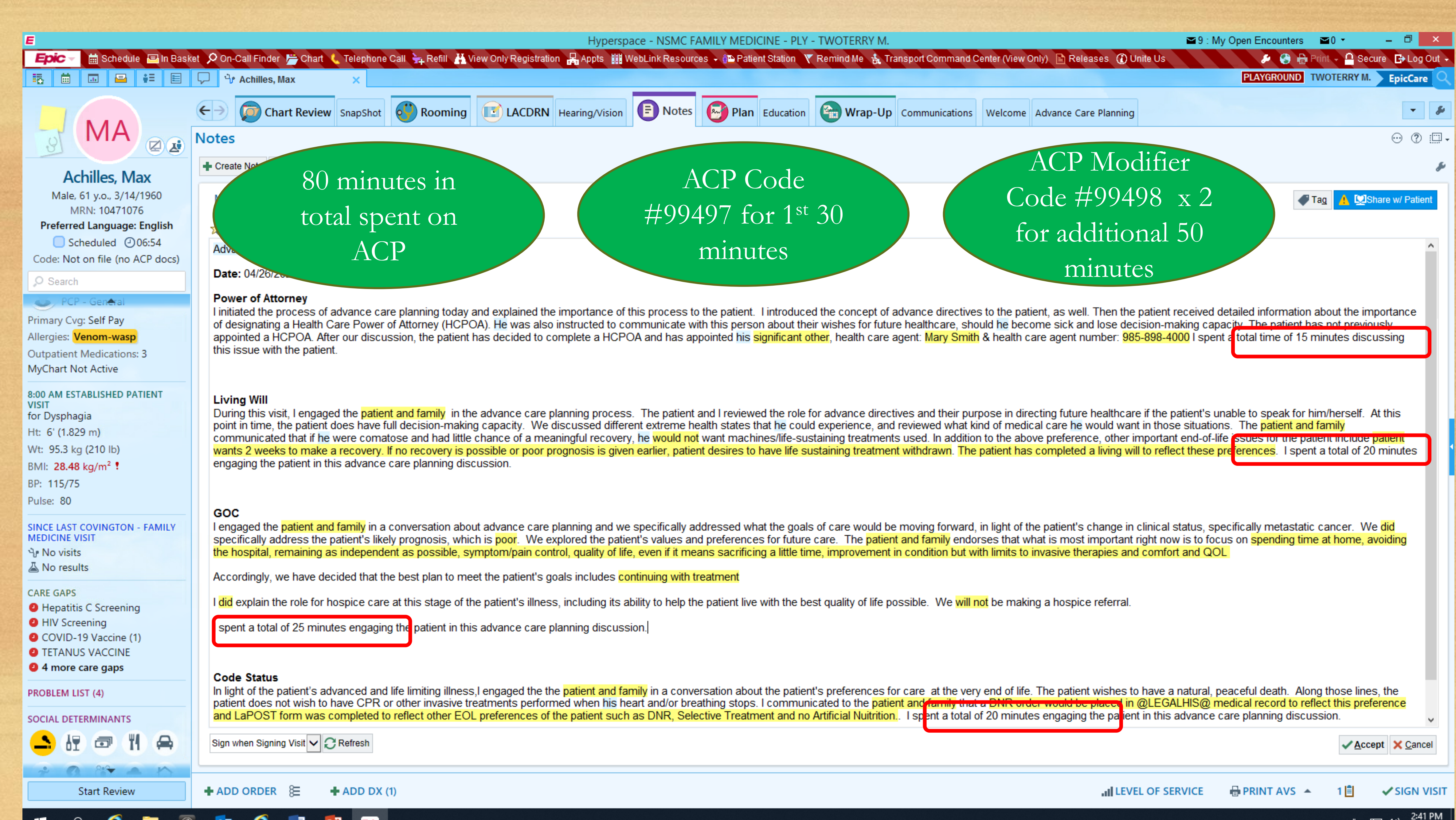
Living Will
During this visit, I engaged the patient and family in the advance care planning process. The patient and I reviewed the role for advance directives and their purpose in directing future healthcare if the patient's unable to speak for him/herself. At this point in time, the patient does have 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.
GOC
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 did specifically address the patient's likely prognosis, which is poor. We explored the patient's values and preferences for future care. The patient and family endorses that what is most important right now is to focus on spending time at home, avoiding the hospital, remaining as independent as possible, symptom/pain control, quality of life, even if it means sacrificing a little time, improvement in condition but with limits to 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 did 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 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 @LEGALHIS@ medical record to reflect this preference and LaPOST 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.
Sign when Signing Visit
Refresh
Accept
Cancel


80 minutes in total spent on ACP
ACP Code #99497 for 1st 30 minutes
ACP Modifier Code #99498 x 2 for additional 50 minutes
Hyperspace - NSMC FAMILY MEDICINE - PLY - TWOTERRY M.
Achilles, Max
Chart Review
SnapShot
Rooming
LACDRN
Hearing/Vision
Notes
Plan
Education
Wrap-Up
Communications
Welcome
Advance Care Planning
MA
Achilles, Max
Male, 61 y.o., 3/14/1960
MRN: 10471076
Preferred Language: English
Scheduled 06:54
Code: Not on file (no ACP docs)
Primary Cvg: Self Pay
Allergies: Venom-wasp
Outpatient Medications: 3
MyChart Not Active
8:00 AM ESTABLISHED PATIENT VISIT
for Dysphagia
Ht: 6' (1.829 m)
Wt: 95.3 kg (210 lb)
BMI: 28.48 kg/m²
BP: 115/75
Pulse: 80
SINCE LAST COVINGTON - FAMILY MEDICINE VISIT
No visits
No results
CARE GAPS
Hepatitis C Screening
HIV Screening
COVID-19 Vaccine (1)
TETANUS VACCINE
4 more care gaps
PROBLEM LIST (4)
SOCIAL DETERMINANTS
Start Review
Notes
Date: 04/26/20
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Sign when Signing Visit
Refresh
Accept
Cancel
ADD ORDER
ADD DX (1)
LEVEL OF SERVICE
PRINT AVS
SIGN VISIT
2:41 PM
4/26/2021

“Serious Illness” Guide in EPIC

EPIC "Serious Illness" Template

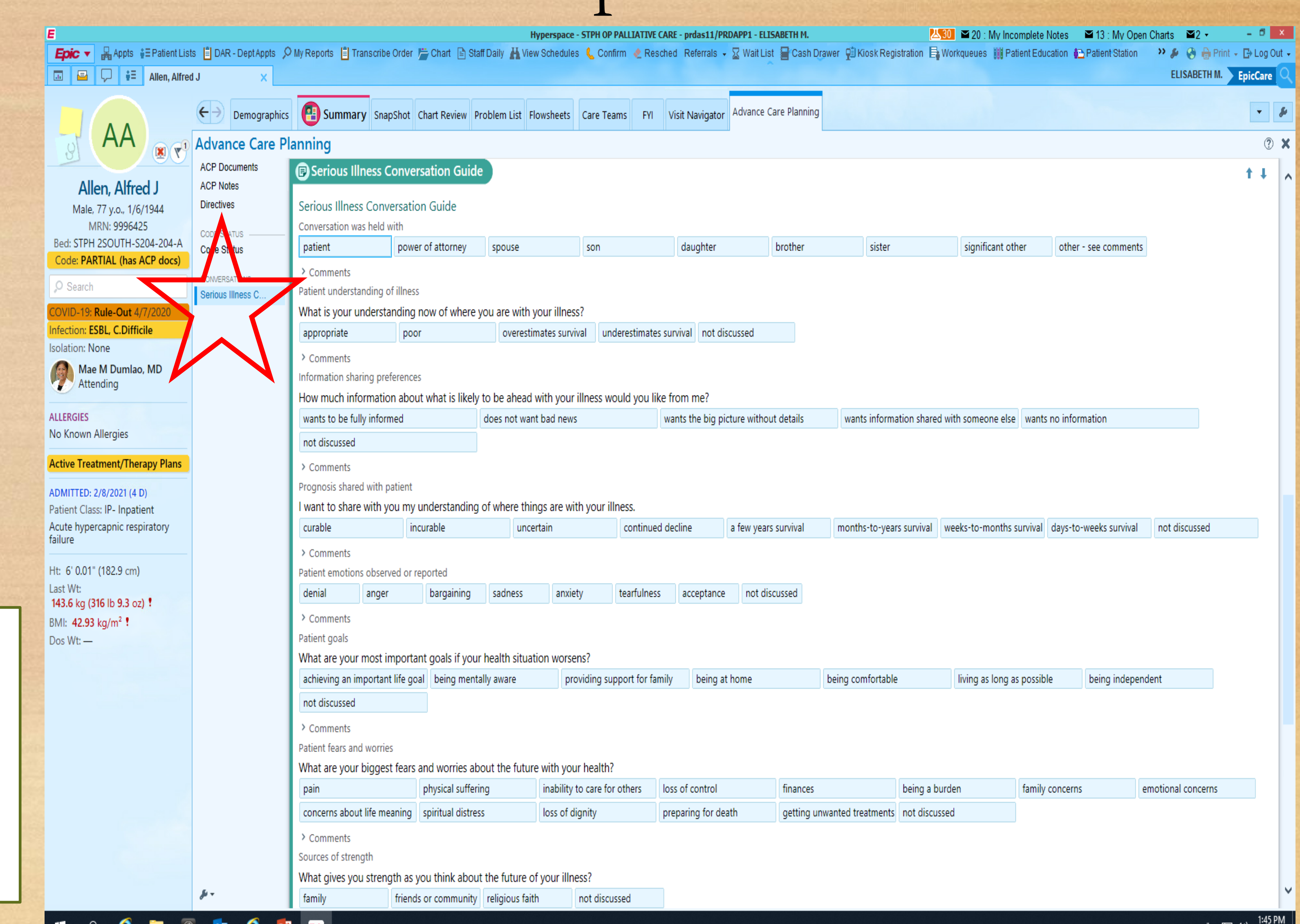
Offers a working template for staff to have higher quality, patient centered conversations

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 single conversation

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



EPIC Serious Illness Guide can now be entered in EMR using ".SICGCOVID" Template

Found in EPIC Banner

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
5. **Close the conversation**
   - Summarize
   - Make a recommendation
   - Check in with patient
   - Affirm commitment
6. **Document your conversation**
7. **Communicate with key clinicians**

Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

SET UP

"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?**"

ASSESS

"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?"

SHARE

"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. 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."

EXPLORE

"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?"

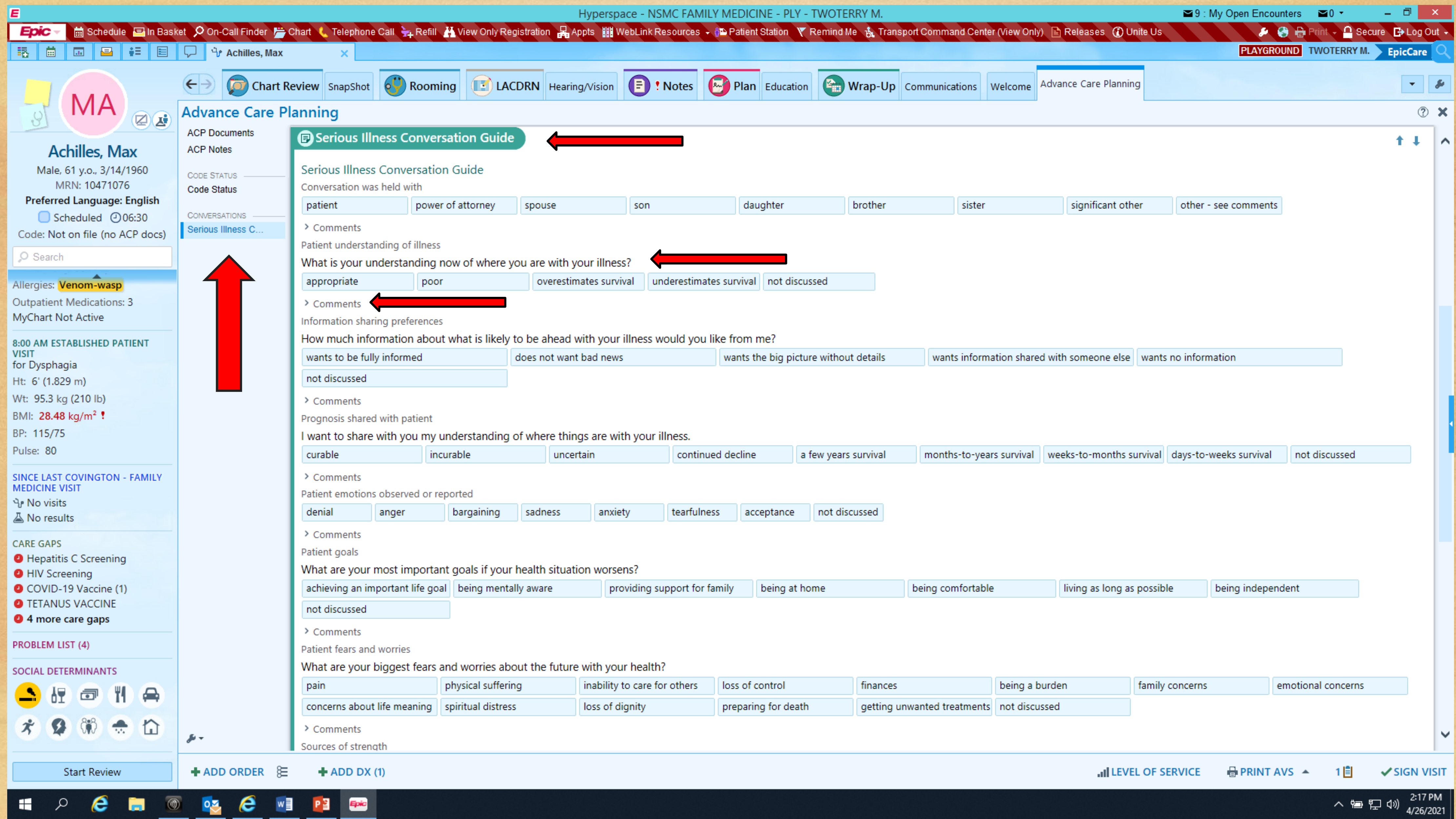
"If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?"

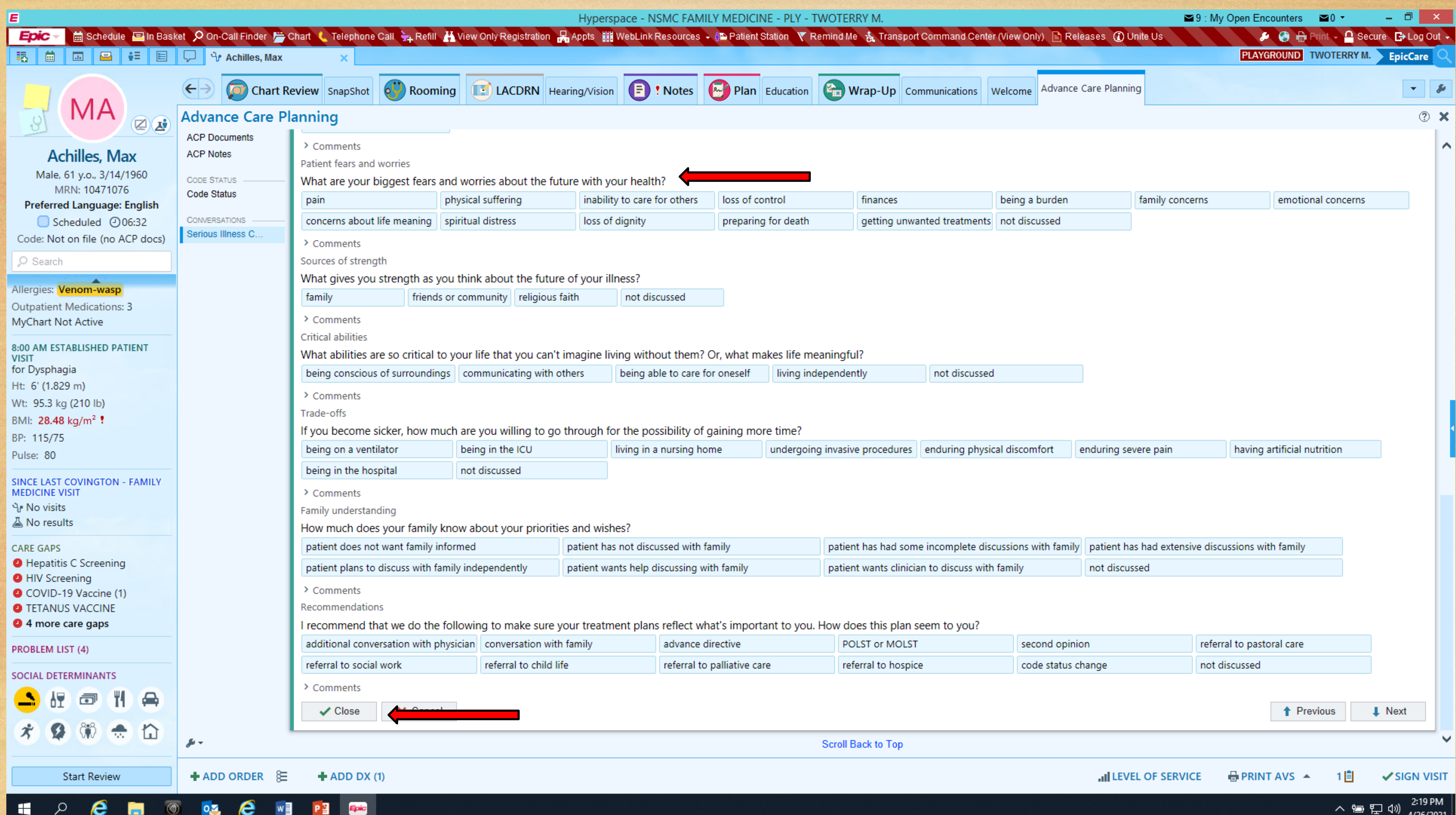
"How much does your **family** know about your priorities and wishes?"

CLOSE

"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?"


Hyperspace - NSMC FAMILY MEDICINE - PLY - TWOTERRY M.
Schedule
In Basket
On-Call Finder
Chart
Telephone Call
Refill
View Only Registration
Appts
WebLink Resources
Patient Station
Remind Me
Transport Command Center (View Only)
Releases
Unite Us
Secure
Log Out
Achilles, Max
PLAYGROUND
TWOTERRY M.
EpicCare
Chart Review
SnapShot
Rooming
LACDRN
Hearing/Vision
Notes
Plan
Education
Wrap-Up
Communications
Welcome
Advance Care Planning
MA
Achilles, Max
Male, 61 y.o., 3/14/1960
MRN: 10471076
Preferred Language: English
Scheduled 06:30
Code: Not on file (no ACP docs)
Allergies: Venom-wasp
Outpatient Medications: 3
MyChart Not Active
8:00 AM ESTABLISHED PATIENT VISIT
for Dysphagia
Ht: 6' (1.829 m)
Wt: 95.3 kg (210 lb)
BMI: 28.48 kg/m²
BP: 115/75
Pulse: 80
SINCE LAST COVINGTON - FAMILY MEDICINE VISIT
No visits
No results
CARE GAPS
Hepatitis C Screening
HIV Screening
COVID-19 Vaccine (1)
TETANUS VACCINE
4 more care gaps
PROBLEM LIST (4)
SOCIAL DETERMINANTS
Start Review
Advance Care Planning
ACP Documents
ACP Notes
CODE STATUS
Code Status
CONVERSATIONS
Serious Illness C...
Serious Illness Conversation Guide
Serious Illness Conversation Guide
Conversation was held with
patient
power of attorney
spouse
son
daughter
brother
sister
significant other
other - see comments
Comments
Patient understanding of illness
What is your understanding now of where you are with your illness?
appropriate
poor
overestimates survival
underestimates survival
not discussed
Comments
Information sharing preferences
How much information about what is likely to be ahead with your illness would you like from me?
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
not discussed
Comments
Prognosis shared with patient
I want to share with you my understanding of where things are with your illness.
curable
incurable
uncertain
continued decline
a few years survival
months-to-years survival
weeks-to-months survival
days-to-weeks survival
not discussed
Comments
Patient emotions observed or reported
denial
anger
bargaining
sadness
anxiety
tearfulness
acceptance
not discussed
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
not discussed
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
not discussed
Comments
Sources of strength
ADD ORDER
ADD DX (1)
LEVEL OF SERVICE
PRINT AVS
SIGN VISIT
2:17 PM
4/26/2021



Hyperspace - NSMC FAMILY MEDICINE - PLY - TWOTERRY M.
9 : My Open Encounters
Epic
Schedule
In Basket
On-Call Finder
Chart
Telephone Call
Refill
View Only Registration
Appts
WebLink Resources
Patient Station
Remind Me
Transport Command Center (View Only)
Releases
Unite Us
Print
Secure
Log Out
Achilles, Max
PLAYGROUND
TWOTERRY M.
EpicCare
Chart Review
SnapShot
Rooming
LACDRN
Hearing/Vision
Notes
Plan
Education
Wrap-Up
Communications
Welcome
Advance Care Planning
MA
Achilles, Max
Male, 61 y.o., 3/14/1960
MRN: 10471076
Preferred Language: English
Scheduled 06:32
Code: Not on file (no ACP docs)
Search
Allergies: Venom-wasp
Outpatient Medications: 3
MyChart Not Active
8:00 AM ESTABLISHED PATIENT VISIT
for Dysphagia
Ht: 6' (1.829 m)
Wt: 95.3 kg (210 lb)
BMI: 28.48 kg/m²
BP: 115/75
Pulse: 80
SINCE LAST COVINGTON - FAMILY MEDICINE VISIT
No visits
No results
CARE GAPS
Hepatitis C Screening
HIV Screening
COVID-19 Vaccine (1)
TETANUS VACCINE
4 more care gaps
PROBLEM LIST (4)
SOCIAL DETERMINANTS
Start Review
Advance Care Planning
ACP Documents
ACP Notes
CODE STATUS
Code Status
CONVERSATIONS
Serious Illness C...
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
not discussed
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
being in the hospital
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
not discussed
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
not discussed
Comments
Close
Previous
Next
Scroll Back to Top
ADD ORDER
ADD DX (1)
LEVEL OF SERVICE
PRINT AVS
SIGN VISIT
2:19 PM
4/26/2021

LaPOST, Vynca & State Registry

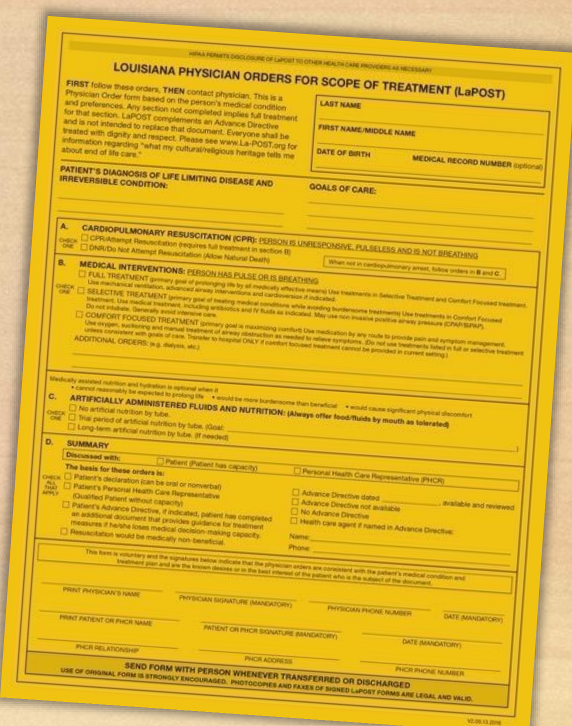
LaPOST

LOUISIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT

REGISTRY

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



HIPAA PERMITS DISCLOSURE OF LaPOST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

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
CHECK ONE
☐ CPR/Attempt Resuscitation (requires full treatment in section B)
☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C.

B. MEDICAL INTERVENTIONS: PERSON HAS PULSE OR IS BREATHING
CHECK ONE
☐ FULL TREATMENT (primary goal of prolonging life by all medically effective means) Use treatments in Selective Treatment and Comfort Focused treatment. Use mechanical ventilation, advanced airway interventions and cardioversion if indicated.
☐ SELECTIVE TREATMENT (primary goal of treating medical conditions while avoiding burdensome treatments) Use treatments in Comfort Focused treatment. Use medical treatment, including antibiotics and IV fluids as indicated. May use non invasive positive airway pressure (CPAP/BiPAP). Do not intubate. Generally avoid intensive care.
☐ COMFORT FOCUSED TREATMENT (primary goal is maximizing comfort) Use medication by any route to provide pain and symptom management. Use oxygen, suctioning and manual treatment of airway obstruction as needed to relieve symptoms. (Do not use treatments listed in full or selective treatment unless consistent with goals of care. Transfer to hospital ONLY if comfort focused treatment cannot be provided in current setting.)
ADDITIONAL ORDERS: (e.g. dialysis, etc.)

Medically assisted nutrition and hydration is optional when it
• cannot reasonably be expected to prolong life • would be more burdensome than beneficial • would cause significant physical discomfort

C. ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: (Always offer food/fluids by mouth as tolerated)
CHECK ONE
☐ No artificial nutrition by tube.
☐ Trial period of artificial nutrition by tube. (Goal:)
☐ Long-term artificial nutrition by tube. (If needed)

D. SUMMARY
Discussed with: ☐ Patient (Patient has capacity) ☐ Personal Health Care Representative (PHCR)
The basis for these orders is:
CHECK ALL THAT APPLY
☐ Patient's declaration (can be oral or nonverbal)
☐ Patient's Personal Health Care Representative (Qualified Patient without capacity)
☐ Patient's Advance Directive, if indicated, patient has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity.
☐ Resuscitation would be medically non-beneficial.
☐ Advance Directive dated ______, available and reviewed
☐ Advance Directive not available
☐ No Advance Directive
☐ Health care agent if named in Advance Directive:
Name:
Phone:

This form is voluntary and the signatures below indicate that the physician orders are consistent with the patient's medical condition and treatment plan and are the known desires or in the best interest of the patient who is the subject of the document.

PRINT PHYSICIAN'S NAME | PHYSICIAN SIGNATURE (MANDATORY) | PHYSICIAN PHONE NUMBER | DATE (MANDATORY)

PRINT PATIENT OR PHCR NAME | PATIENT OR PHCR SIGNATURE (MANDATORY) | DATE (MANDATORY)

PHCR RELATIONSHIP | PHCR ADDRESS | PHCR PHONE NUMBER

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

USE OF ORIGINAL FORM IS STRONGLY ENCOURAGED. PHOTOCOPIES AND FAXES OF SIGNED LaPOST FORMS ARE LEGAL AND VALID.

LaPOST Registry

The Lousiana 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

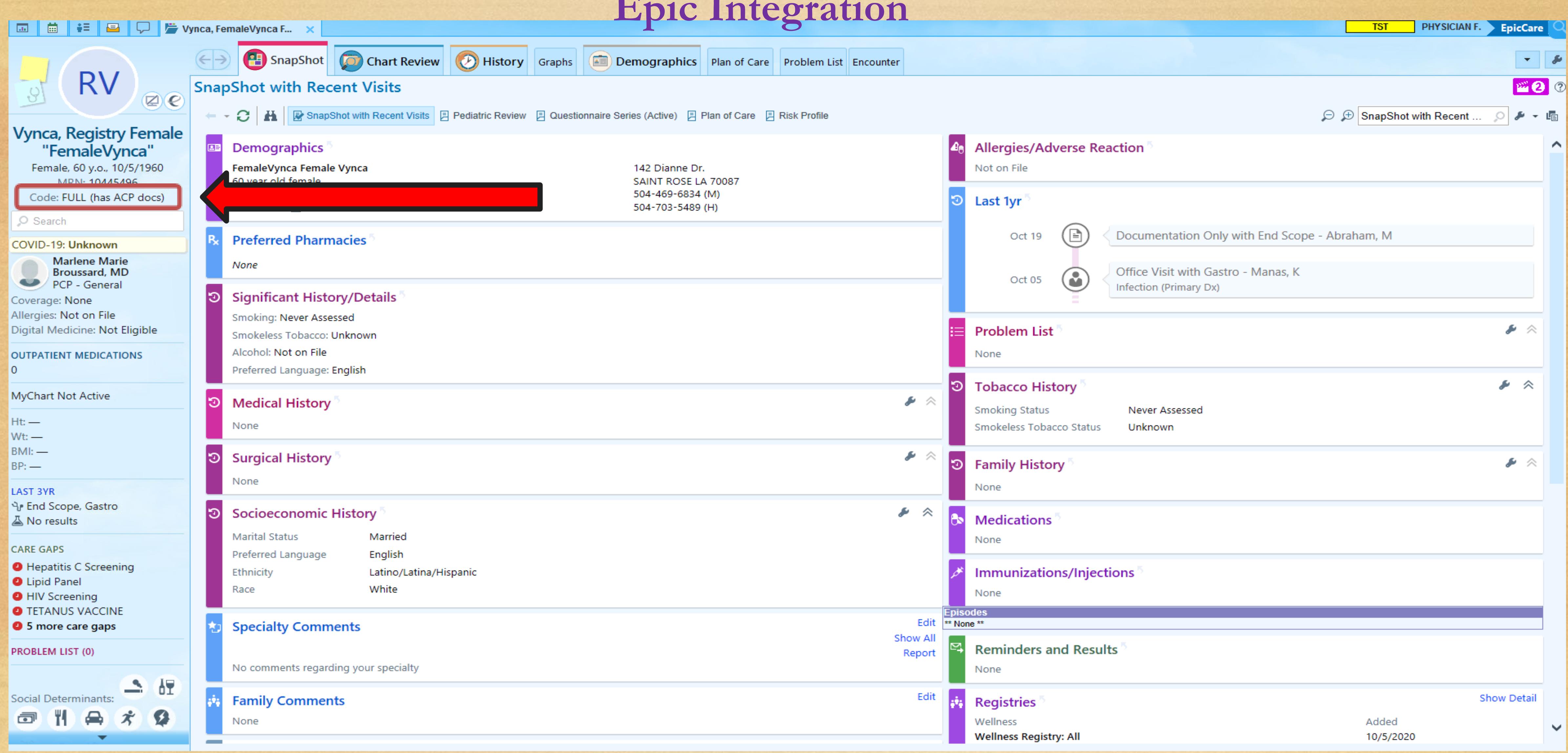
LaPOST Registry

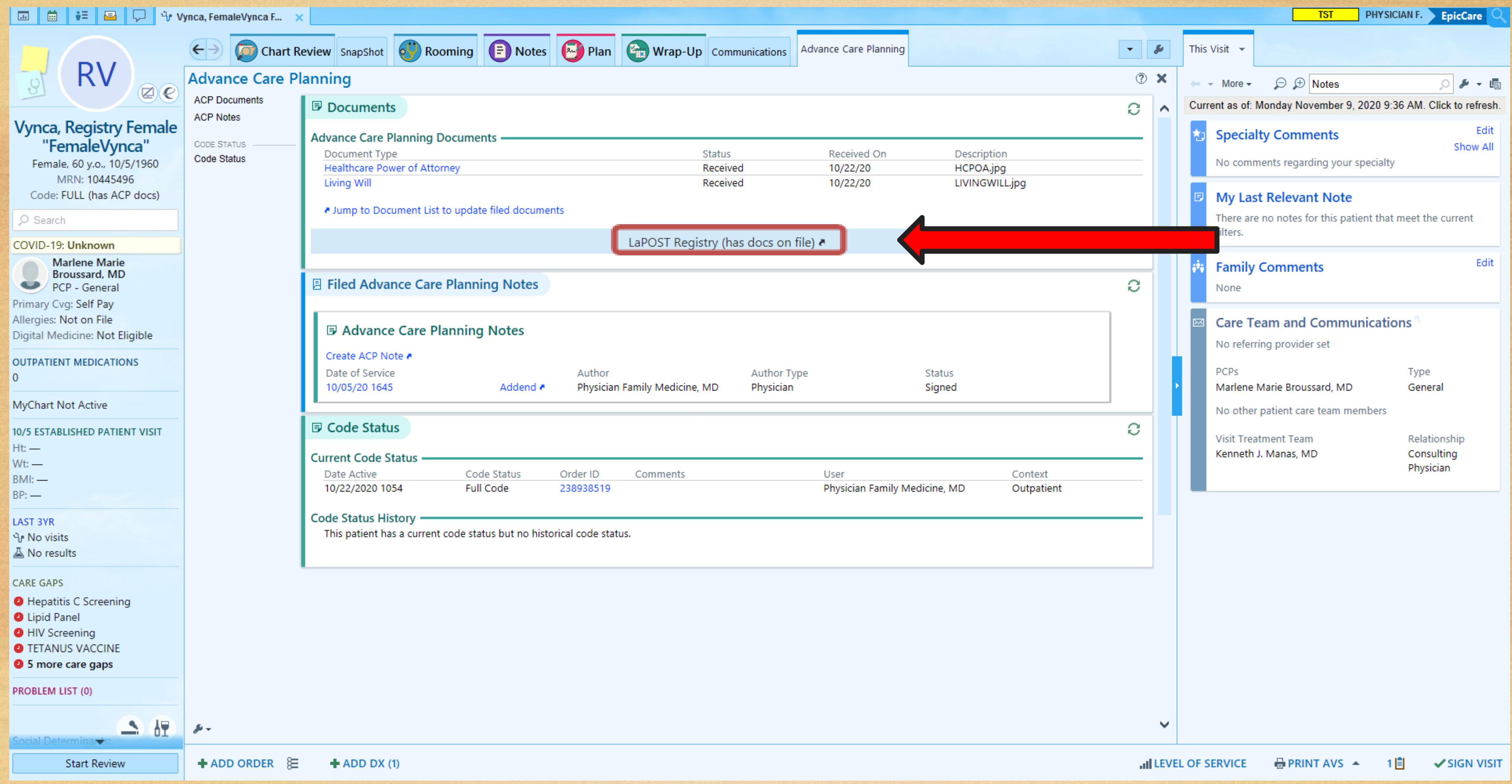
- ACO
- Family
- Hospital
- State Registry
- Physician Practice
- Home Health
- Emergency Medical Services
- Skilled Nursing Facility
- Payers
- Hospice

Epic Integrated LaPOST Registry – Key Benefits

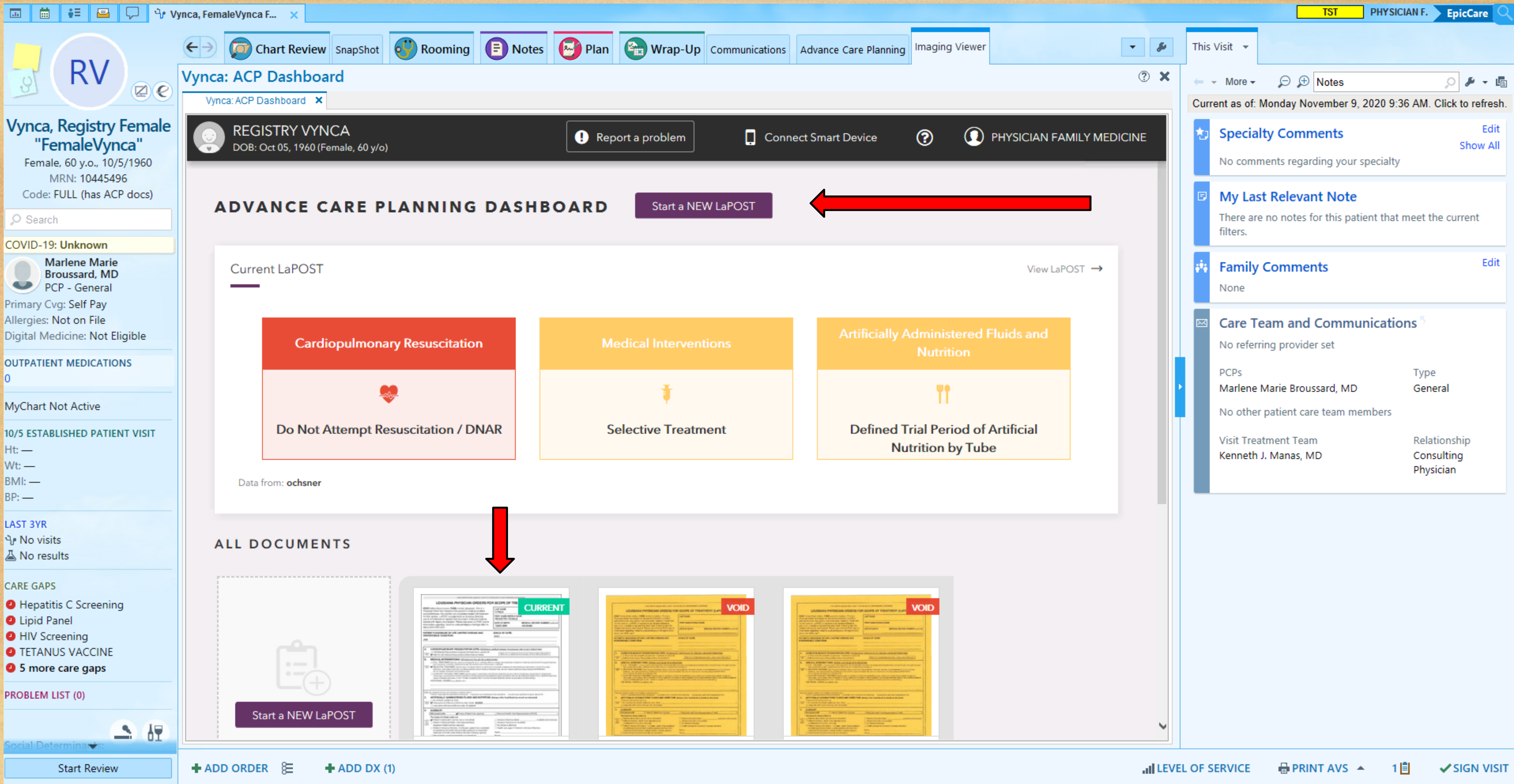
- Offers health care providers an online tool to electronically complete and submit accurate, legally valid, error-free LaPOST forms
- Offers one-click access from Epic to a sustainable, statewide LaPOST registry network
- Provides a simple, intuitive user interface
- Provides a single source of truth for LaPOST documents
- Enhanced ACP Conversations with embedded educational resources
- Renders a printable PDF of the LaPOST form in all state-supported languages

Epic Integration





Vynca, FemaleVynca F...
TST
PHYSICIAN F.
EpicCare
Chart Review
SnapShot
Rooming
Notes
Plan
Wrap-Up
Communications
Advance Care Planning
This Visit
RV
Vynca, Registry Female "FemaleVynca"
Female, 60 y.o., 10/5/1960
MRN: 10445496
Code: FULL (has ACP docs)
Search
COVID-19: Unknown
Marlene Marie Broussard, MD
PCP - General
Primary Cvg: Self Pay
Allergies: Not on File
Digital Medicine: Not Eligible
OUTPATIENT MEDICATIONS
0
MyChart Not Active
10/5 ESTABLISHED PATIENT VISIT
Ht: —
Wt: —
BMI: —
BP: —
LAST 3YR
No visits
No results
CARE GAPS
Hepatitis C Screening
Lipid Panel
HIV Screening
TETANUS VACCINE
5 more care gaps
PROBLEM LIST (0)
Start Review
Advance Care Planning
ACP Documents
ACP Notes
CODE STATUS
Code Status
Documents
Advance Care Planning Documents
Document Type
Status
Received On
Description
Healthcare Power of Attorney
Received
10/22/20
HCPOA.jpg
Living Will
Received
10/22/20
LIVINGWILL.jpg
Jump to Document List to update filed documents
LaPOST Registry (has docs on file)
Filed Advance Care Planning Notes
Advance Care Planning Notes
Create ACP Note
Date of Service
Author
Author Type
Status
10/05/20 1645
Addend
Physician Family Medicine, MD
Physician
Signed
Code Status
Current Code Status
Date Active
Code Status
Order ID
Comments
User
Context
10/22/2020 1054
Full Code
238938519
Physician Family Medicine, MD
Outpatient
Code Status History
This patient has a current code status but no historical code status.
More
Notes
Current as of: Monday November 9, 2020 9:36 AM. Click to refresh.
Specialty Comments
Edit
Show All
No comments regarding your specialty
My Last Relevant Note
There are no notes for this patient that meet the current filters.
Family Comments
Edit
None
Care Team and Communications
No referring provider set
PCPs
Type
Marlene Marie Broussard, MD
General
No other patient care team members
Visit Treatment Team
Relationship
Kenneth J. Manas, MD
Consulting Physician
ADD ORDER
ADD DX (1)
LEVEL OF SERVICE
PRINT AVS
SIGN VISIT



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LAST 3YR
No visits
No results
CARE GAPS
Hepatitis C Screening
Lipid Panel
HIV Screening
TETANUS VACCINE
5 more care gaps
PROBLEM LIST (0)
Start Review
Vynca: ACP Dashboard
REGISTRY VYNCA
DOB: Oct 05, 1960 (Female, 60 y/o)
Report a problem
Connect Smart Device
PHYSICIAN FAMILY MEDICINE
ADVANCE CARE PLANNING DASHBOARD
Start a NEW LaPOST
Current LaPOST
View LaPOST
Cardiopulmonary Resuscitation
Do Not Attempt Resuscitation / DNAR
Medical Interventions
Selective Treatment
Artificially Administered Fluids and Nutrition
Defined Trial Period of Artificial Nutrition by Tube
Data from: ochsner
ALL DOCUMENTS
Start a NEW LaPOST
CURRENT
VOID
VOID
More
Notes
Current as of: Monday November 9, 2020 9:36 AM. Click to refresh.
Specialty Comments
Edit
Show All
No comments regarding your specialty
My Last Relevant Note
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No referring provider set
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Marlene Marie Broussard, MD
General
No other patient care team members
Visit Treatment Team
Relationship
Kenneth J. Manas, MD
Consulting Physician
ADD ORDER
ADD DX (1)
LEVEL OF SERVICE
PRINT AVS
SIGN VISIT

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FIRST NAME/MIDDLE NAME

DATE OF BIRTH **MEDICAL RECORD NUMBER** (optional)

PATIENT'S DIAGNOSIS OF LIFE LIMITING DISEASE AND IRREVERSIBLE CONDITION:

GOALS OF CARE:

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

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

CHECK ONE
- ☐ No artificial nutrition by tube.
- ☐ Trial period of artificial nutrition by tube. (Goal: ______)
- ☐ Long-term artificial nutrition by tube. (If needed)

D. SUMMARY

Discussed with: ☐ Patient (Patient has capacity) ☐ Personal Health Care Representative (PHCR)

The basis for these orders is:

CHECK ALL THAT APPLY
- ☐ Patient's declaration (can be oral or nonverbal)
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- ☐ Health care agent if named in Advance Directive:

Name: ______

Phone: ______

This form is voluntary and the signatures below indicate that the physician orders are consistent with the patient's medical condition and treatment plan and are the known desires or in the best interest of the patient who is the subject of the document.

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V2.06.13.2016

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 2021

PRIORITIES FOR MEDICAL CARE AND TREATMENT OPTIONS FOR SERIOUS ILLNESS

Priorities for Medical Care		
LIVING LONGER	**MAINTAINING CURRENT HEALTH**	**COMFORT**
• Live as long as possible, even if I do not know who I am or who I am with • Be in the hospital and receive all care my doctors think will help me, even if it means relying on machines to keep me alive	• Live longer, if quality of life and comfort can be achieved • Be in the hospital, if needed, for effective care • Stop treatment that does not work or makes me feel worse • Allow a natural death if my heart or breathing stops	• Live the rest of my life focusing on my comfort and quality of life • Avoid the hospital and being on machines • Allow a natural death if my heart or breathing stops

Treatment Options for Serious Illness		
FULL TREATMENT **Sustaining life by all medically effective means**	**SELECTIVE TREATMENT** **Maintaining health while avoiding burdensome treatments**	**COMFORT-FOCUSED TREATMENT** **Maximizing comfort through symptom management**
Includes: • Medication and treatment to keep you comfortable • Emotional and spiritual care	**Includes:** • Medication and treatment to keep you comfortable • Emotional and spiritual care	**Includes:** • Medication and treatment to keep you comfortable • Emotional and spiritual care
May include: • Being in the hospital and Intensive Care Unit (ICU) • A trial of full treatment, if desired, e.g., ventilator • IV medications and IV fluids • Long-term tube feedings • CPR, intubation, and/or ventilator	**May include:** • Being in the hospital but AVOIDING the ICU • Non-invasive positive airway pressure • A trial of selective treatment, if desired, e.g., non-invasive positive airway pressure • IV medications and IV fluids • Short-term tube feedings	**May include:** • Being in the hospital ONLY if comfort needs not met • Oxygen, suction, and manual treatment of airway for comfort • Medications by mouth • Food and fluids by mouth, if able
	Does NOT include: • CPR, intubation, and/or ventilator	**Does NOT include:** • CPR, intubation, and/or ventilator

Materials developed by Respecting Choices®.
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RC 3105_ASCareTrmt_v06.19 CE

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

First Steps	**Who?**	**Where?**
Addresses Advance Care Planning among a healthy population, any age -HCPOA and LW discussion	Staff who room our patients: Nurses Medical Assistants	Outpatient (primary care)
Advanced Steps	**Who?**	**Where?**
Addresses Advance Care Planning among a chronically ill population who *may* be in their last 1-2 years of life -LaPOST discussion	MD/APP Nurses Social Workers Chaplain	Outpatient Inpatient
SDMSI – Shared Decision Making in Serious Illness	**Who?**	**Where?**
Addresses shared decision making with family, caregivers, & patients in times where a patient is **CURRENTLY** facing difficult treatment choices	MD/APP	Inpatient Outpatient

Length of Class & Required Pre-Work

	First Steps	Advanced Steps	SDMSI
Class time	Full day	Full day	Half day
Pre-work	Online modules (4) assigned by Respecting Choices	Online modules (6) assigned by Respecting Choices	none

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

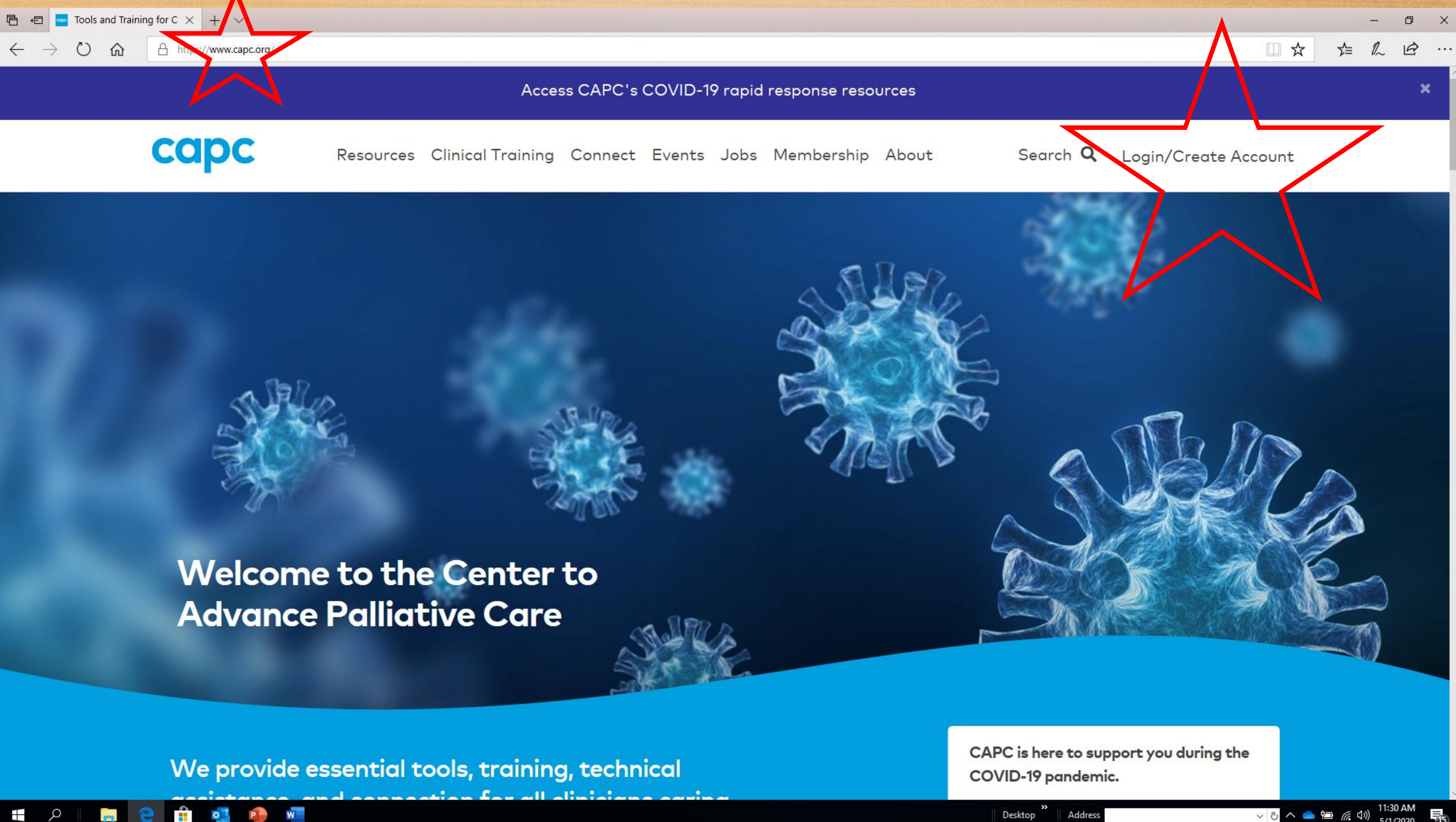
- Webpage has section "What My Cultural /Religious Heritage Tells Me About End Of Life Care"
- Can Consult Chaplin Services For Anyone Having Difficulty With EOL Decisions And Their Spirituality

Center to Advance Palliative Care

www.capc.org

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.**



Tools and Training for C
https://www.capc.org/
Access CAPC's COVID-19 rapid response resources
capc
Resources
Clinical Training
Connect
Events
Jobs
Membership
About
Search
Login/Create Account
Welcome to the Center to Advance Palliative Care
We provide essential tools, training, technical
CAPC is here to support you during the COVID-19 pandemic.
Desktop
Address
11:30 AM

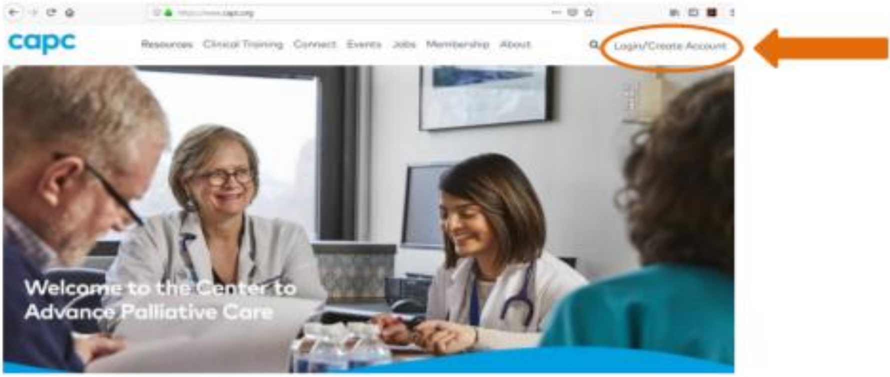
Creating a CAPC User Account

CAPC Website Update, March 2019

How to Create a CAPC User Account

Creating an Account

1. Visit 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.

Organization

Required

Continue

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 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

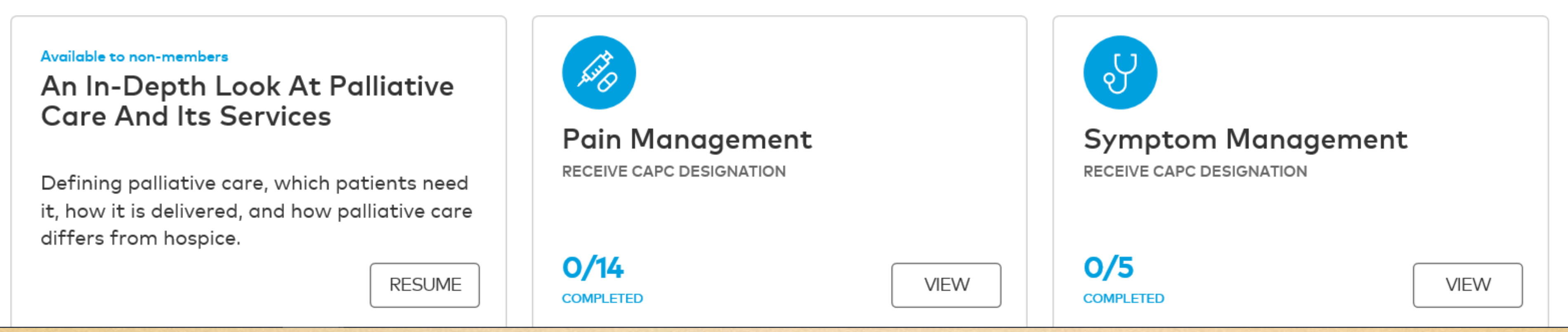
For assistance with content, please email memberrelations@capc.org

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.



Link to CAPC Continuing Education Curriculum

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

2. Select class “Internal”

Class: Internal Referral

3. Enter comments

Sched Instruct:
Comment: Patient aware of the referral: Yes
Symptom Management: {Symptom Management- end 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

Question	Answer	Comment
Referred to Region: Only select region(s) you would like the patient to be seen in if it is outside of the current encounter's department.	New Orleans Metro	

Search:

Title
Emotional Support
Disease Education
Symptom Management
Family Consultation
Spiritual consult
Advanced Directives
DNR
End of Life/Hospice
Goals of care discussion/advance care planning
Pain Management
Other Symptoms Management
Withdrawal of Interventions
Patient and Family support
Comfort care
Hospice referral and discussion
Other (please specify)

Referring providers can currently only chose 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