ADVANCE CARE PLANNING CONVERSATIONS-

NATIONAL HEALTH CARE DECISIONS DAY

VIKRANTA SHARMA MD, FAAHPM

PALLIATIVE CARE PHYSICIAN

OBJECTIVES

- Why end-of-life conversations should be part of a provider's plan to deliver excellent care.

- Best practices for health care providers to have advance care planning conversations with patients and families.

DISCLOSURES

- No financial conflicts to report.
- Member NJ State TASK force for Conversation Of Your Life and POLST Committee
- Medical Director Palliative Care and Hospice VNAHG and CSHC.
- Clinical Assistant Professor, Department of Family Medicine and Community Health, Rutgers Robert Wood Johnson Medical School.

COVID-19

- **Mild disease** – fever, cough and shortness of breath, are most common symptoms.
- **Moderate disease** - multi lobar interstitial pneumonia with hypoxia requiring hospitalization.
- **Severe disease** – severe hypoxia requiring ventilation , sepsis with inflammatory response , thrombosis , ARDS and Acute kidney injury.
- Treatment – no clear cut treatment available.
- No vaccine yet.
- Mainstay of treatment is supportive care.
- Throwing the kitchen sink may not be in best interest of some chronically ill patients.
- What is most important to the patient and family?

GENERAL GUIDELINES FOR COVID-19 PANDEMIC

- Observe social distancing, physical distancing.
- Wash hands frequently for 20- 30 seconds with soap and water or alcohol based sanitizer.
- Clean frequently touched surfaces.
- Restful 7-8 hours of sleep.
- Regular exercise.
- Mindfulness, LKM, stress reduction.
- Nutritious diet.

COMMUNITY DWELLING PATIENTS

- Antipyretics
- Antihistamines
- Fluids
- Rest
- Prone positioning
- ? Antibacterial / antiviral
- Flu and pneumonia shots – prevent severe disease ?

PATIENTS IN NURSING HOMES

- Isolation precautions – 14 days or no symptoms for 72 hours or Covid negative
- Antipyretics
- Antihistamines
- Fluids
- Prone positioning
- Establish healthcare proxy, Advance directive .
- Do they have a terminal condition, that suggest ICU stay would be ill advised?
- Discuss Do not hospitalize – IF Goals of care imply that comfort focused care is desirable and accepted
- Some of these individuals are better served by having familiar staff/ surroundings, than strict hospital respiratory isolation in these times
- Double masking (patient and healthcare worker)

HOSPITALIZED PATIENT

- If hospitalized, they are admitted with multi-lobar pneumonia or other chronic disease exacerbation.
- Usually need higher oxygen than afforded at home.
- Are they anticipated to potentially land in ICU?
- If so – address the anticipated course in ICU. Ventilation, barotrauma from high PEEP, septic shock , thrombotic states, acute kidney injury, need for dialysis or ECMO.
- Same precautions as in facility + negative pressure rooms + supportive clinical trials.
- Pronate if patient can cooperate , or specialized beds , where available .

WHY SHOULD END-OF-LIFE CONVERSATIONS BE A PART OF PROVIDER'S PLAN TO DELIVER EXCELLENT CARE?

- Care aligned with patient preferences and goals is the best care . This may differ from the standard of care.
- Physicians are uniquely positioned to help in Shared decision making by discussing their insights.
- Focus on establishing a respectful relation, by understanding their values.
- What do they hope for?
- What do they fear?
- What are their support systems?
- Help them plan for a future they might face IF they are not able to speak for themselves

PATIENT SELF DETERMINATION ACT

- Capacitated adults have the right to make their own healthcare treatment decisions.
- Affirmed by U.S. Judicial system , by case law, state law and federal law U.S. Supreme court.

THE REALITY

- ACD only becomes effective if the patient is not capable of stating their wishes.
- Approximately 30% of the adults now have some sort of advance directive. The numbers are growing daily
- Ensuring that an individual’s wishes are known and honored requires serious reflection and candid discussion with family members and healthcare providers

STEPS FOR ADVANCE CARE PLANNING

- Reflection on priorities
- Communication with your preferred healthcare proxy
- Documentation in medical chart so it is readily visible and available to care providers
- Implementation by medical staff

REFLECT ON PRIORITIES

- Do I wish to spend my last days or weeks in a nursing home?
- What sort of disability is absolutely unacceptable for me?
- Who will care for me when I am physically incapable?
- What place do I want to be at the end of life?

APPOINTING THE HEALTH CARE PROXY

- HAS to be someone whose values match yours.
- Not necessarily your eldest child or your spouse.
- They should agree with your decisions.
- Can be a friend.
- Can be a legal guardian.

BEST PRACTICES FOR DOING ACP

- Identify declining function –ADLs and IADLS.
- Identify major chronic illness- organ system involvement.
- Track hospitalizations and visit frequency in ER observation unit or physician office .
- Recent serious admissions – ICU care.
- Recent history of Acute stroke or other events that cause neurodegenerative decline.
- Long term healthcare residents – dementia , frailty , or other neurodegenerative disorders.
- Patient preferences.
- Chronic Heart, Lung, Liver or Renal disease.

SPIKES PROTOCOL

- Setting up the interview.
- Assessing the patient's perception.
- Obtaining the patients invitation.
- Giving the knowledge and information to the patient.
- Addressing the patients emotions with empathic responses.
- Strategy and summary.

RESPECTFUL SETTING

- Private, quiet place.
- Beepers / phone to buzzer.
- Sit down.
- Gather all the data and review consults.
- Let the family talk.
- What have they been told.

DECISION MAKING UNIT

- Patient /caregivers.
- POA
- Most decisions are still made collectively by the family.

WHAT DO THEY KNOW

- LISTEN
- Ask for clarifications .
- How has the patient deteriorated functionally, nutritionally and mentally in last 6 months.

HOW MUCH INFORMATION DO THEY WANT

- Some want the whole truth.
- Some defer to family.
- Shunning information may be a valid coping mechanism for some individuals .

SHARED DECISION MAKING

- Warning shot.
- Medical facts in simple language.
- Avoid blunt statements / impossible choices.
- Small chunks of information and check for understanding.
- Avoid “nothing more can be done“.

ADDRESS EMOTIONS WITH EMPATHETIC RESPONSES

- **Silence, disbelief, crying, denial or anger.**
- Observe
- Identify
- Understand/state the reason for the emotion
- Pause and reflect

EMPATHETIC RESPONSES

- I can see how upsetting this is to you.
- I can tell you weren’t expecting to hear this.
- I am sorry to have to tell you this.
- This is very difficult for me also.
- I was also hoping for a better result.

EXPLORATORY QUESTIONS

- Tell me more about it?
- Could you explain that to me one more time?
- You said it frightened you?
- What about this worries you the most?
- You mentioned you are concerned for your children/ family, tell me more?

VALIDATE

- I can understand how you felt that way.
- Your understanding of the treatment and its effects on you is very good.
- It appears that you have thought through this very well.
- Many other patients have had a similar experience.

ACP TAKE AWAY

- Goal is to understand patients values.
- Begin to plan with the patient for future medical care in a non threatening way.
- Signposting : what I wanted to put on the agenda today was to plan your medical care for the future – its called ACP . have you heard of it?
- Normalize the process. Do you think I need one? It is normal not to have one . I discuss it with all my patients. Could I take a minute to explain why it is worth thinking about.
- Talking about surrogate decision makers – spouse or any other person who understands your view point and can articulate it if you are not able to talk to your doctors. Give choice A or B.
- Hope for the best, but plan for something we are hoping doesn't happen
- What does peaceful look like for you
- What does not suffering mean to you

IDENTIFYING END OF LIFE GOALS

- Recognize that as death nears, most people share similar goals.
- Maximizing time with family/ friends in familiar places.
- Avoiding unnecessary pain and suffering. Make appropriate treatment plans.
- Maintain functionality and dignity.
- Not be a burden.
- Try to identify clear/attainable milestones they wish to reach and support them.
- Offer formal contact with Hospice and Palliative care Professionals.

QUESTIONS

BILLING

- **99497**
- **99498**
- **Section 1135 waiver under CMS**