Objectives

- Learn the History, Definitions, and Goals of Advance Care Planning (ACP)
- Understand Barriers to ACP and Advance Directive Completion
- Understand Potential solutions to ACP barriers
- Learn basic ACP conversation facilitation skills
- Practice ACP conversation facilitation
- Ask Questions

Crash Course in ACP History

- ACP was introduced in the 1960’s in the USA, as life sustaining medical technologies were becoming more successful.
- In 1990, the Patient Self Determination Act was passed.
- Reimbursement for ACP discussions was proposed in 2009 ACA legislation.
- A HealthStyles survey in the USA in 2009 and 2010 revealed 26% of those surveyed had completed an advance directive.
Definitions

- **Advance Care Planning**
  - Lifelong, ongoing process
  - Open-ended discussion of health care wishes, values, and preferences
- **Advance Directives**, which may include:
  - Living Will
  - Health Care Power of Attorney/Health Care Proxy/Durable Power of Attorney

To create new norms, you have to understand people's existing norms and barriers to change. You have to understand what's getting in their way.

Atul Gawande, "SLOW IDEAS"
Barriers to ACP

Professionals
- Do not routinely offer ACP education; it is not part of the workflow.
- Discomfort with sensitive conversations.
- Timing.
- Afraid to invoke the idea of death or remove patients’ hope.
- Do not feel well trained in conducting ACP discussions or the details of legal advance directives.
- Worry about legal implications of withholding treatments at any stage of life.
- Lack of time and compensation to conduct ACP conversations.
- Lack of documentation in the EMR.

Barriers to ACP

Patients
- Low “health literacy”.
  - What questions should I ask?
  - What does the terminology mean?
  - What does my diagnosis mean?
- Low literacy or learning difficulties.
- Language.
- Lack of education about the purpose of ACP and advance directives.
- Distrust of the medical system.

Barriers to ACP

- Desire to “stay positive”.
- Lacking a PCP.
- Isolated (especially LGBT and low income older adults).
- Vague, non-specific terminology is not explored.
- Lack of urgency, “just haven’t gotten around to it”.
- Strict witnessing requirements in some states.
Potential Solutions/Barrier Busters

- Educate health care providers about ACP 4, 6, 11, 15
- Teach health care providers how to initiate ongoing ACP discussions 5, 6, 11, 14
- Oncologists to discuss prognosis and care goals as early as possible 5, 12
- Educate patients in the ACP process and clarify possible medical events 4, 5

Barrier Busters

- View ACP as a "team sport" for Physicians, nurses, social workers, and other staff.
- Providers need to understand their own fears, concerns, goals for care 15
- Use multimedia
Barrier Busters

- Engage the palliative care team
- Make it clear ACP is to be ongoing and revisited
- Engage early in outpatient settings
- Present ACP as "standard of care"
- Build trigger for ACP discussion into EMR?
- Use the "surprise question" with cancer patients to trigger ACP discussions

Why does this matter?
Why do ACP?

- Personally
  - May direct medical personnel to provide more of the treatment you want, rather than wish to avoid
  - Increases chances of dying in desired setting
  - Patient and family distress has been shown to be reduced when wishes are known ahead of time
  - Help educate about common end of life concerns
  - May increase survival rates and lifespan
  - May lead to better quality of life
  - Does not reduce hope or cause psychological harm

- Institutionally
  - Improved customer service scores
  - Increased patient satisfaction
  - Cost savings when futile end of life care is avoided
  - Less intense medical care is engaged
  - Fewer hospital days are accrued

- Societally
  - People who complete advance directives spend much less money on end of life care overall
Limitations of ACP

- Impossible to predict every possible health situation
- Unrealistic expectations may develop
- Can infer a measure of control that may not be possible
- Requires ongoing conversation
- For a very small percentage of people, the conversation is emotionally harmful

Skills Building

- There are many models of ACP to utilize
  - Respecting Choices (Honoring Choices)
  - The Conversation Project
  - The One Slide Project
  - Advance Care Planning Canada
- Common features
  - How to keep the conversation ongoing
  - How to choose a health care proxy
  - How to explore health care wishes and preferences
  - How to communicate health care wishes and preferences
The 5 D’s
Review your advance care plan every:
• Decade – each new decade of your life
• Death – of a loved one
• Divorce – if agent is your spouse or legal partner
• Diagnosis – with a serious condition
• Decline – upon significant decline in health

(Thank you to Honoring Choices Wisconsin)

Choosing a Health Care Decision Maker
• Is the person willing to serve as a health care decision maker?
• Does the person know the patient very well, including as much as possible about health care wishes, preferences and definition of acceptable quality of life?
• Is the person willing to follow the patient’s wishes, even if they disagree with them?
• Is the person able to make difficult decisions in stressful situations?

(Thank you to Honoring Choices Wisconsin)

Exploring Health Care Wishes
• Explore past experiences
• Help patient discuss health care wishes
• Clarify vague statements
• Identify any religious or cultural needs around health care
• Help make lists of questions to discuss with other professionals
• Help educate about potential treatment risks and benefits
• Help explore understanding of current illness and possible complications/trajectory
Completing an advance directive

- Can be formal or informal, but record something!
- Various options for completing legal directives; read your state statute
- Answer questions about forms and documentation
- Assist patient in completing documentation of wishes

Additional Resources
Additional Resources

Can You and Your Loved Ones Answer These Questions?
1. On a scale of 1 to 5, where do you fall on this continuum?
   ![Scale Image]
   5 - Don't get up on me no matter what. Be your natural
   4 - Oprions and support more possible
   3 - If there were a choice, would you prefer to die at home, or in a hospital?
   2 - Could a loved one correctly describe how you'd like to be treated in the case of a terminal illness?
   1 - Is there someone you trust who you've appointed to advocate on your behalf when the time is near?

Have you completed any of the following: written a living will, appointed a healthcare power of attorney, or completed an advance directive?

References
References


