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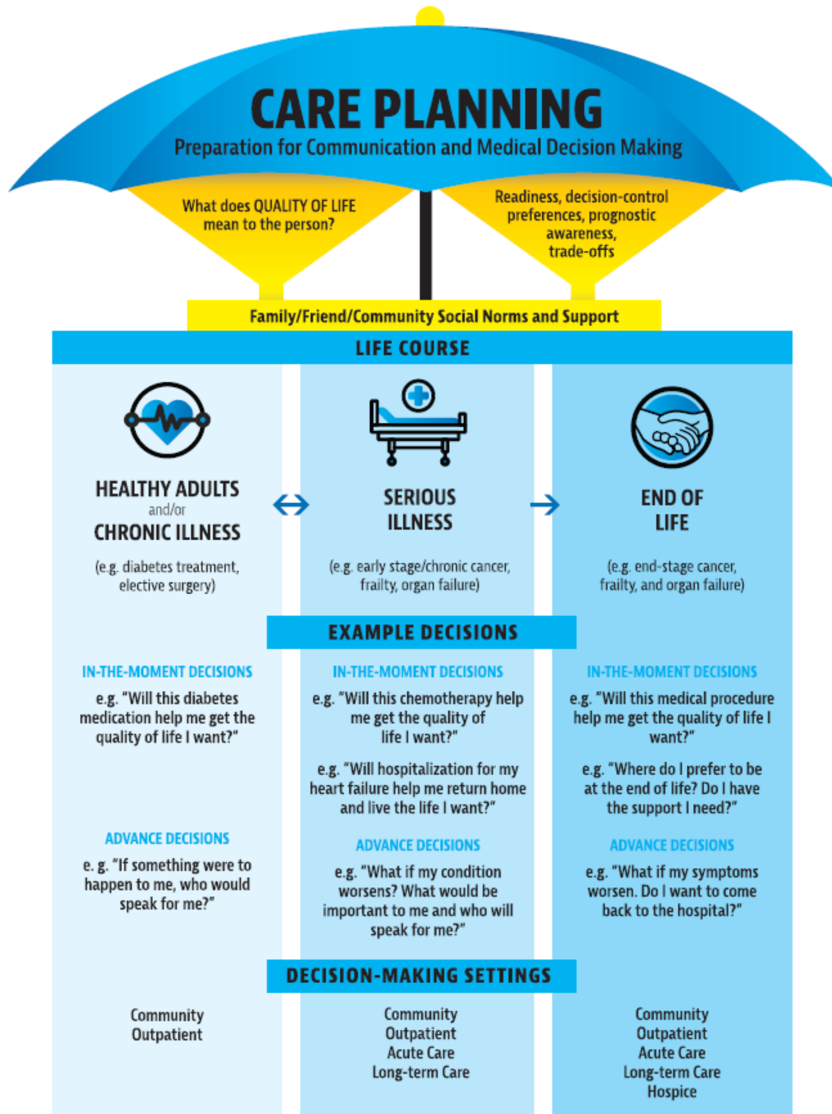
How to have conversations about advance care planning – aka the treatment you want!

Hillary Lum, MD, PhD
Division of Geriatric Medicine
University of Colorado



OBJECTIVES

- Identify how to routinely integrate ACP conversations into nursing home care
- Adapt ACP conversations to people with dementia and their surrogate decision maker
- Appropriate use of the Colorado MOST form

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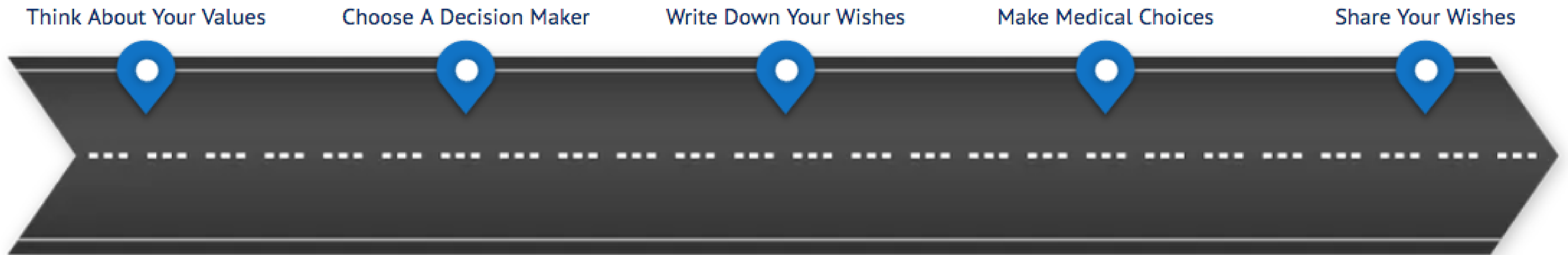
The care planning umbrella: The evolution of advance care planning.
Hickman SE, Lum HD, Walling AM, Savoy A, Sudore RL. J Am Geriatr Soc. 2023

Advance Care Planning: A Process



www.ColoradoCarePlanning.org

In the words of a fellow nursing home social worker:

Advance care planning is to make sure that we're getting the elders what they want at the end of life, and making sure we're meeting their needs and the family needs.

Interviews from ACP Specialists

(NIA grant, Hickman and Unroe), 2024

We Can Be “Conversation Ready”

Key Principles

1. **Exemplify** this in our own lives to more fully understand benefits and challenges
2. **Connect with patients** and families of choice in a culturally and individually respectful manner
3. Engage with patients and families to understand **what matters most** for current and future care
4. **Steward** reliably patients' care preferences

Your Conversation Starter Guide

For Caregivers of People with Alzheimer’s or Other Forms of Dementia

How to understand what matters most to someone living with Alzheimer’s or another form of dementia, and help them have a say in their health care.

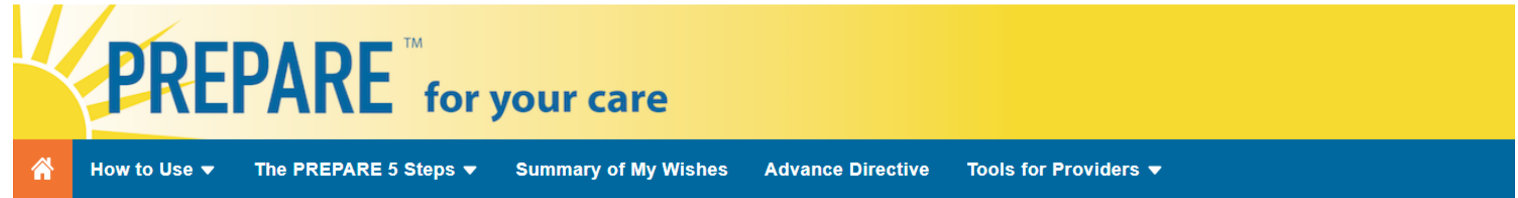
the conversation project

©2023 The Conversation Project, an initiative of the Institute for Healthcare Improvement (IHI)

https://theconversationproject.org/wp-content/uploads/2020/12/DementiaGuide.pdf

Lally KM, McCutcheon Adams K, Zambeaux A, Joshi C, Sokol-Hessner L. *How to Talk to Your Patients about End-of-Life Care: A Conversation Ready Toolkit for Clinicians*. Boston: Institute for Healthcare Improvement; 2019. (Available at ihi.org)

1) **Exemplify** this in our own lives to understand the benefits and challenges

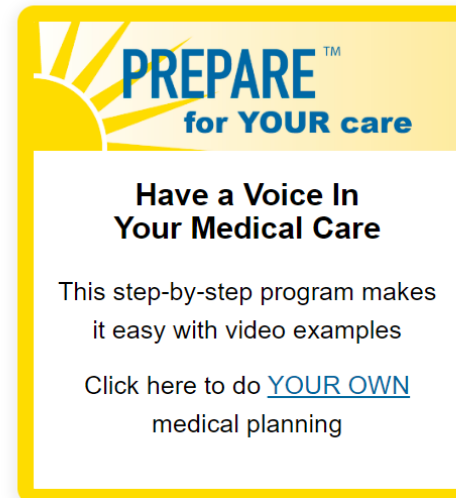


- Have you talked about what matters most to you, if you are not able to speak for yourself?

PREPARE has 2 programs with video stories to help you:

1. Have a voice in **YOUR OWN** medical care
2. Help **OTHER PEOPLE** with their medical planning and decisions

- Have you designated a medical power of attorney?



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Learn more at https://prepareforyourcare.org/en/welcome

How to Start ACP Conversations

2) Connect with patients and families in a culturally and individually respectful manner

Prior to connecting, prepare as a team!

- Ensure the right people (potential decision makers) can be present
- Do your "homework" of knowing about the resident in advance – discuss with the team questions about prognosis; prior ACP; recommended treatments
- Prepare the surrogates/family for the conversation – consider an ACP handout
- Attend to the physical environment – maximize ability to be present together

Who would you like involved in discussions about your care?

- Include the resident based on cognitive ability and decision-making preferences
- Explore personal, family, cultural background with curiosity, limiting assumptions about family/loved ones, marriage

- No default decision maker in Colorado - a spouse or other relatives do not automatically have decision making authority
- If MDPOA form is not completed, a medical proxy process selects the medical decision maker without the direct say of the patient

Medical Durable Power of Attorney (MDPOA)

- **Most important form for everyone age 18+**
- Designates who will make medical decisions when the resident lacks capacity
- MDPOA can meet with the care team, view medical records, and make decisions related to the resident's health care
- Correct phone numbers are essential

- "Your agent is not making decisions for you, they are following your wishes."
  – advance care planning client
- MDPOA can only make health care decisions when someone is unable to make them for themselves

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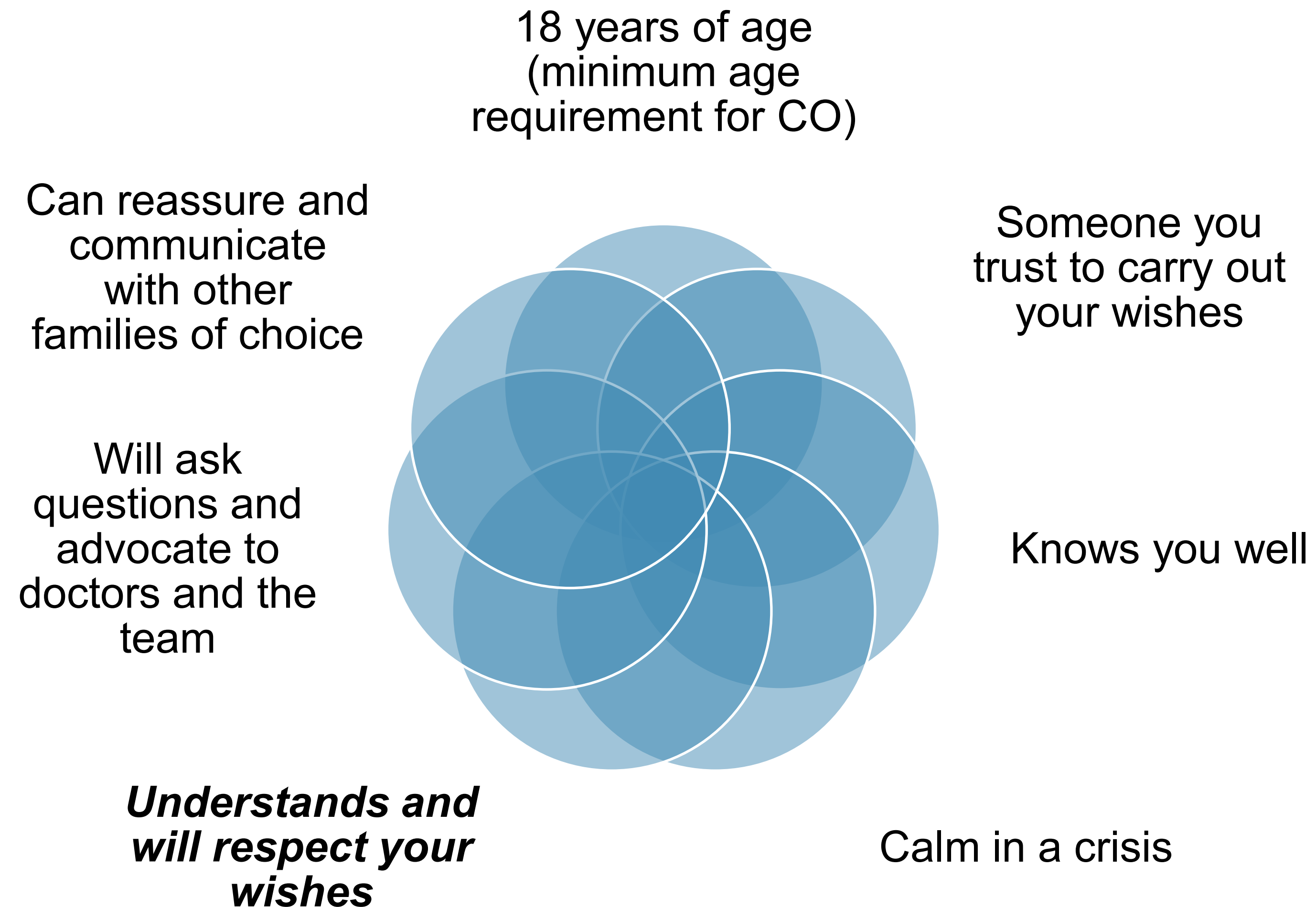
Source: Your Right to Make Healthcare Decisions from the Colorado Hospital Association
cha.com/wp-content/uploads/2017/03/medicaldecisions_2011-02.pdf

Choosing a Health Care Agent/MDPOA



3) **ENGAGE** to understand **what matters most** for current and future care

As you're engaging in ACP, remember to share the benefits of these conversations:

"You can speak up and have a say in your care. Getting health care often involves choices that impact your life and wellbeing in different ways. Treatments only work if they work for you.

Thus, it's important for me to learn more about what matters to you."

01 **Talk Up the Benefits**

02 **Present Choices for Every Step**

03 **Use Positive Ones**

04 **Invite Dialogue, and Not Just Once**

05 **Invoke a New Team**

https://seriousillnessmessaging.org/quick-guides/acp/

3) **ENGAGE** to understand **what matters most** for current and future care

Review previous discussions and documented preferences for care	"What conversations have you had with others about the care you want to receive?
Assess knowledge and understanding of illness, prognosis, current/future situation	"Thinking about the future, I think it is important to discuss what the expected course of your [condition] may be."
Ask the patient/surrogate about their values, goals, and concerns for the future	"What is important for you at this point?" "What are some of your worries as we discuss these issues?"

Express support throughout: We'll figure this out together. Let's make a plan that makes sense to you for your care.

https://www.acpdecisions.org/goals-of-care-conversations-a-best-practice-step-by-step-approach/

3) **ENGAGE** to understand **what matters most** for current and future care

Present Choices for Every Step & Use Positive Ones

- Suggest treatments and interventions that align with identified goals and values
- Summarize, make a recommendation, and affirm commitment to care – “What are your thoughts? We want a plan that works for you.”

Instead of…	Do this…
Trying to educate people about the differences between palliative care and hospice	Illustrate a single choice and the consequences — from the patient’s point of view
Emphasizing the worst - case scenario of not exercising choice...	Illustrate how a person living with a serious illness made a positive choice that expressed an important value

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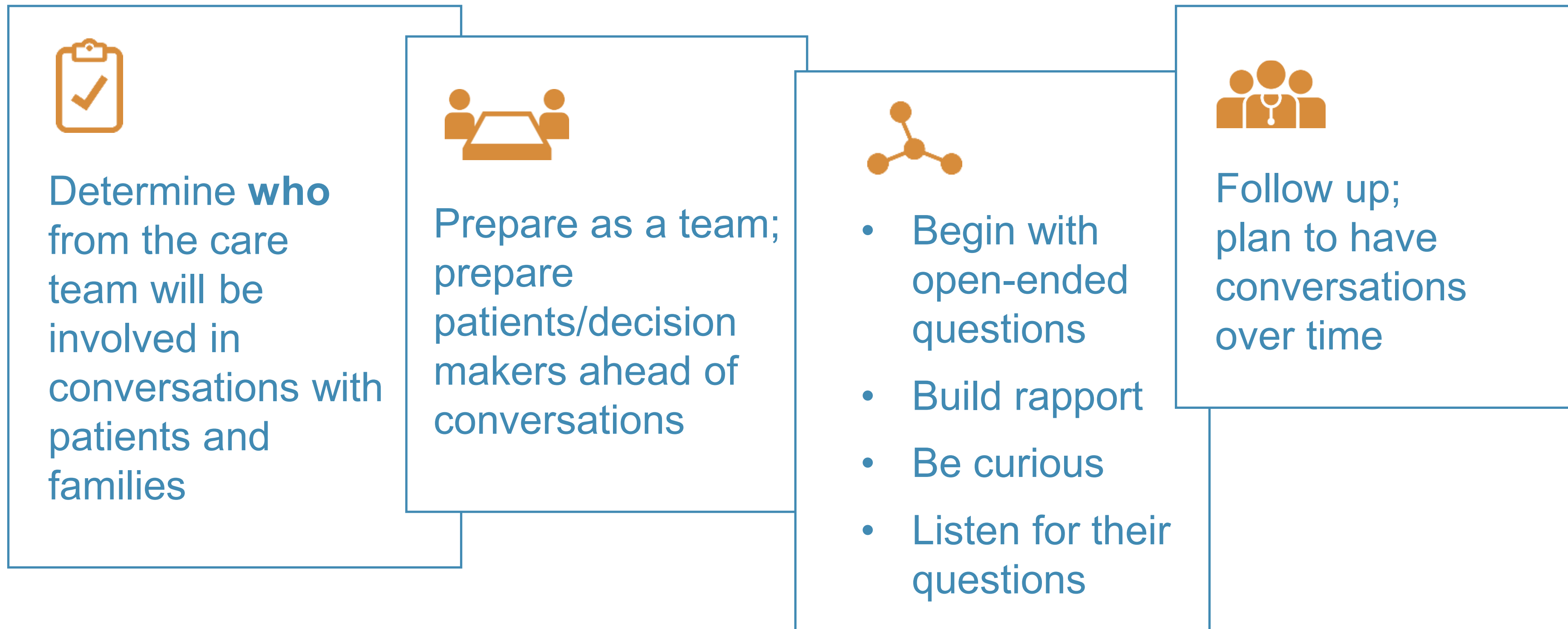
ENGAGE in learning what is important to each person

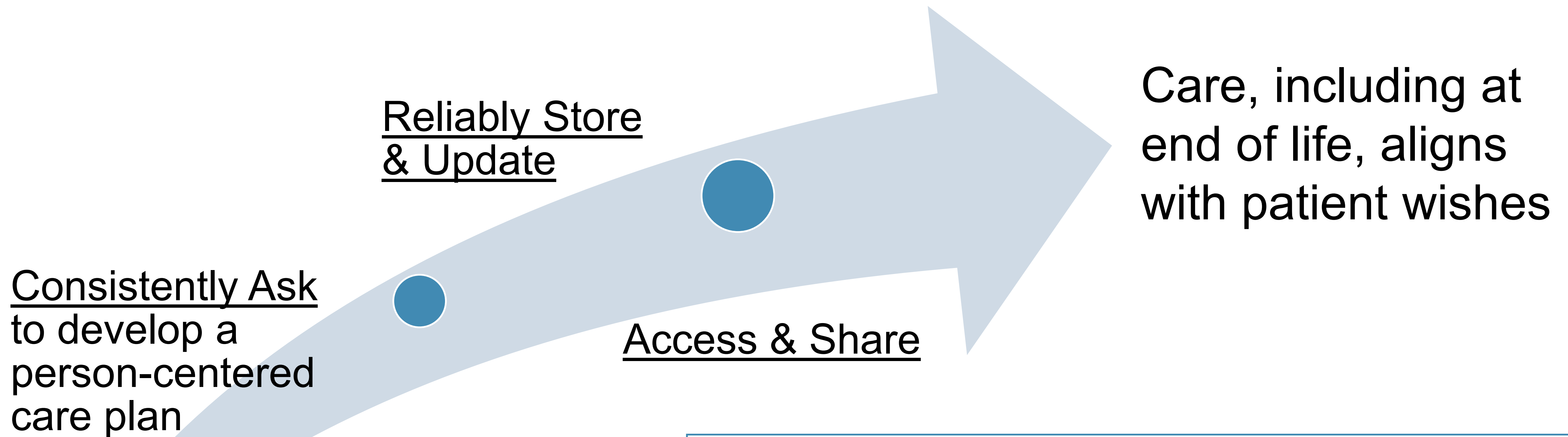
If we ask, we may learn a lot:

- Who they trust or how their surrogate is involved
- What some deeply held personal beliefs are
  - Key stories and meaningful activities based on their values
  - What they enjoy now
- What they think of their health conditions
  - What they may be worried about
  - Current needs, concerns, preferences related to NH care
- What their preferences are about life-sustaining treatments
- What their vision of a good death may be
- What their funeral arrangements and after death wishes are

Key Points: ENGAGE as a team with patient and families



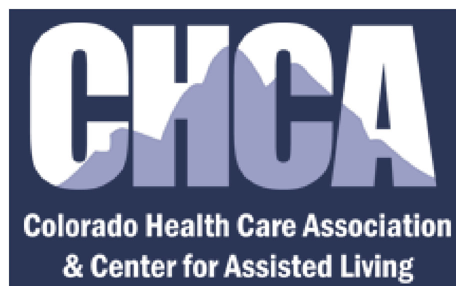
4) **Steward** reliably patient's care preferences and decisions



Refine processes as a team:

- Document the conversation in medical record
- Incorporate into care planning meetings
- Communicate across settings during care transitions
- Update with changes

MOST Training for Assisted Living and Skilled Nursing/ Long-Term Care Communities



CENTER FOR IMPROVING
VALUE IN HEALTH CARE

MOST Training for Assisted Living and Skilled Nursing/Long-Term Care Communities

This on-demand learning goes over the Medical Orders for Scope of Treatment (MOST) form, a one-page, double-sided document that consolidates and translates patient preferences for key life-sustaining treatments (CPR, medical interventions and artificially-administered nutrition) into medical orders. The MOST form is always voluntary and is intended for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. This on-demand learning includes a post-training knowledge assessment to support your learning and implementation processes.

Time to Complete:
30 minutes

Target Audience:
healthcare professionals, medical providers, surveyors

https://myemail.constantcontact.com/MOST-Training-for-Assisted-Living-and-Skilled-Nursing-Long-Term-Care-Communities.html?soid=1118124549863&aid=NujdI6GP9N4

MOST forms <u>cannot</u> be required

- As stated in C.R.S. 15-18.7-108 "A healthcare facility shall not require a person to have executed a MOST form as a condition of being admitted to, or receiving medical treatment from, the healthcare facility"

- MOST is intended for seriously ill or frail people at high risk of life-threatening medical event.

- MOST forms should be completed with a trained individual, as part of an ACP conversation

- MOST forms should **<u>not</u>** be included in admission packets.

10 Tips To Help Care Communities Use the MOST Form Correctly

1. MOST form cannot be mandated. ("A healthcare facility shall not require a person to have executed a MOST form as a condition of being admitted to, or receiving medical treatment from, the healthcare facility" per C.R.S. 15-18.7-108) Facilities with policies requiring MOST completion are in violation of state law. To comply with CMS requirements, facilities solely need to advise residents of the right to complete advance directives and document that discussion. Form should not be included in admission paperwork or move-in packets (lost opportunity for conversation, form may not be understood, sends message it must be completed).
2. MOST form is not appropriate for everyone. Only intended for seriously ill or frail people at high risk of life-threatening medical event. Additionally, not everyone wishes to state CPR wishes for reasons such as cultural practices or religious beliefs. Alternative documents to comply with requirements are a CPR directive or Acknowledgment of Notice of My Right to State Advance Directives.
3. Any care community staff member who understands MOST program may initiate MOST conversation and prepare form with resident or decision-maker if resident wants a form. Resident must have decisional capacity to complete form; if not, decision-maker should be contacted. Refer specific medical questions to healthcare providers.
4. Demographic box at top right of form must be completed, preferably by person preparing the form.
5. Conversation is essential to ensuring resident's goals are documented. Care must be taken not to check boxes without a discussion. After verifying understanding of choices, resident or decision-maker and physician/APN/PA must sign and date form.
6. In the absence of advance directives or MOST form, American standard of medical care requires administration of full life-saving measures. Ensure this practice is understood.
7. Readily recognizable Astrobrights® "Vulcan Green" or "Terra Green"paper is preferred but any color or white paper is acceptable. Copies, scans and faxes are allowed.
8. MOST form is portable and should accompany residents on transfers to and from hospitals and care communities. Resident or decision-maker should be asked if resident has MOST form. Another form should not be completed just because resident changes location or has a new provider.

https://civhc.org/wp-content/uploads/2023/09/10-Tips-to-Use-MOST-in-Care-Communities_2023-Upadte.pdf

Where will you start?

Getting practical

- Convene your team to talk about ACP
- Get honest feedback from the staff, patients, residents, and care partners about your current culture and processes
- Discuss ideas for next steps to better ask and create plans of care around what matters most
- It all starts with a conversation!

Caring for the Ages amda

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Goals-of-Care Discussions: Is Your Team Conversation Ready?

By Carolyn Kazdan, MHSA, NHA, BCPA

DOI: https://doi.org/10.1016/j.carage.2024.02.041

Is Your Team Fully Prepared to Have These Conversations

Having meaningful goals-of-care discussions is vital for delivering person-centered care that aligns with each individual's unique goals, preferences, and priorities. These conversations can be difficult, and staff don't always feel empowered or competent when talking with patients or health care surrogates about life-sustaining treatments.

Is Your Team Fully Prepared to Have These Conversations

https://www.caringfortheages.com/article/S1526-4114%2824%2900073-8/fulltext

Start Small:

- Incorporate brief role plays into a team meeting
- A Wellness initiative that includes incentives for completing a health care proxy
- Host a table in your facility with advance care planning documents and resources
- Partner with your local hospital or community agency to host a larger community event

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Additional Items to Note

Advance Care Planning Resources

- *https://civhc.org/programs-and-services/advance-care-planning/*
- *www.ColoradoCarePlanning.org*
- *https://seriousillnessmessaging.org/using-the-toolkit/*
- *https://theconversationproject.org/*
- *www.PrepareForYourCare.org*

- *MOST Form and other information can be found:*
  - *https://civhc.org/programs-and-services/most-program/*
  - *Top 10 tips for Communities*