Hospice Austin
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The GIFT (Giving Instructions For Tomorrow) Project

made possible by a grant from

St David's Foundation

Advance Care Planning
"The Conversation."

The subject no one wants to talk about…

ADVANCE CARE PLANNING

The GIFT Project

Giving Instructions For Tomorrow


I'm not wearing a costume. I'm here to take your sou—
Holy S full size Snickers
Nevermind Margaret we're good
Facebook.com/JimKBenton — © JimBenton.com

Disclosures

- Conflicts of interest
- Requirements for successful completion

Learning Outcomes and Objectives

- How to initiate and facilitate Advance Care Planning (ACP) conversations with patients and families
- Discuss common barriers surrounding ACP discussions
  - Healthcare Providers
  - Patients/Families
- Identify and discuss Texas advance directives
- Discuss Center for Medicare/Medicaid Services (CMS) position on provider reimbursement for ACP discussions

Headline on "The Onion"

"Death rate holds steady at 100%."

Advance Care Planning (ACP)

- A process of communication between healthcare providers, patients and their families/medical power of attorney or healthcare proxy, with a purpose of identifying individualized goals of care that will shape future clinical care, through informed decision-making based on what fits the patient's personal values and preferences.
- Advance care planning is NOT about making immediate decisions.

CMS encouraging ACP discussions

Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) pays for voluntary Advance Care Planning (ACP) under the Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (OPPS). ACP enables Medicare beneficiaries to make important decisions that give them control over the type of care they receive and when they receive it. https://www.cms.gov

- January 1, 2016 Medicare began to reimburse healthcare professionals for having ACP conversations. This is a time based element for billing w different2 codes
  - first 30 minutes of ACP (code 99497)
  - every 30 minutes of ACP discussion after the initial code, documentation needs to reflect that there is progression with the ACP conversation (code 99498)

Why talking matters

Half of all people over 65 who are admitted to a hospital are unable to make decisions for themselves.

92% of people say that talking with their loved ones about end of life care is important…

32% have actually done so

Source: The Conversation Project National Survey (2018)

21% of people say they haven't had the conversation because they don't want to upset their loved ones.

53% say they'd be relieved if a loved one started the conversation.

95% say they are willing or want to talk about their end-of-life wishes.

Source: The Conversation Project National Survey (2018)

80% of people say that if seriously ill, they would want to talk to their doctor about wishes for medical treatment toward the end of their life.

18% report having this conversation with their doctor

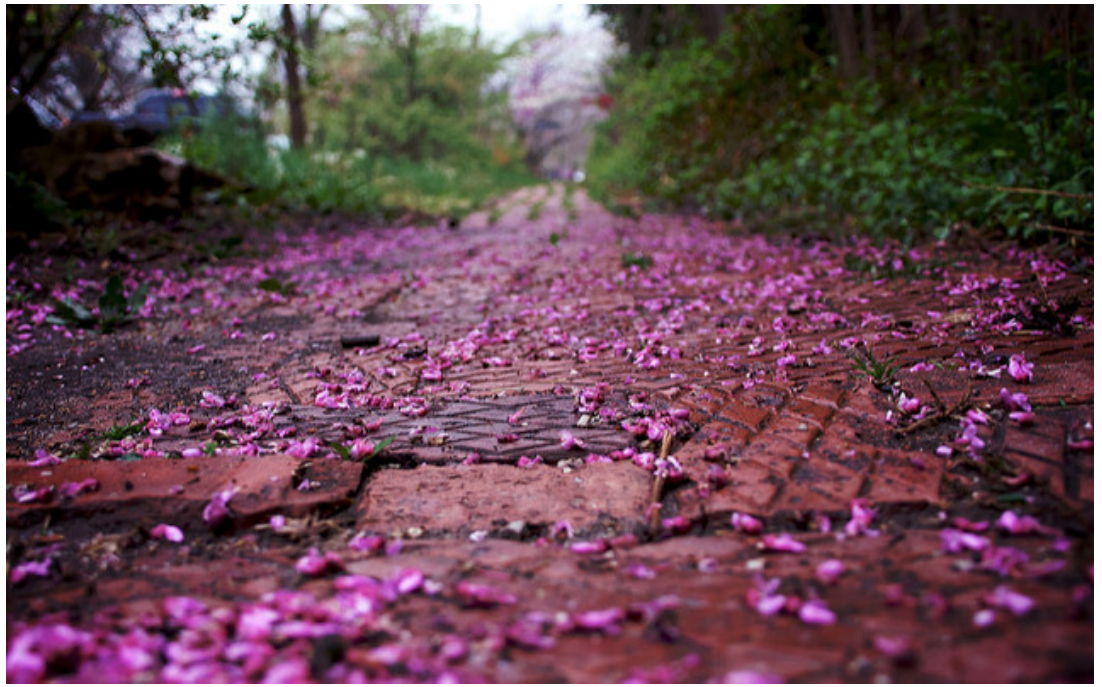
Source: Survey of Californians by the California healthcare foundation 2012 and Kaiser Family Foundation Serious Illness in Late Life Survey (2017)

97% say it is important to put their wishes in writing.

37% have actually done it

Source: Kaiser Family Foundation Serious Illness in Late Life Survey (2017)

You can choose your own adventure



ACP leads to better outcomes

Earlier conversations about patient's goals and priorities in serious illness are associated with:

- Improved quality of life
- higher patient satisfaction
- Goal driven care based on preferences and values
- fewer hospitalizations
- better patient and family coping
- an eased burden of decision-making for families

Common barriers to discussing advance care planning

- Healthcare Providers
  - Time
  - Skill
  - Clarity

- Patients
  - Feeling it's "too soon"/fear of the subject
  - Poor communication between patients and family
  - Health literacy
  - Cultural, racial, and historical influences

ACP conversations may look different based on whether or not patients are living with an illness or medical condition

If patients DO NOT have a serious illness or condition:	**Advance care planning conversations are "insurance" for unexpected events**
If patients live with a chronic illness or condition:	**Provide information about the condition and what challenges patients may face in the future**
If patients are facing late stages of a serious illness:	**Hope for the best AND prepare for what to expect if the illness worsens.**

Your Conversation Starter Kit

When it comes to end-of-life care, talking matters.

Institute for Healthcare Improvement

the conversation project

CREATED BY THE CONVERSATION PROJECT AND THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

Generously distributed by:

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It's a Jungle out there!
by HAGEN
promise me Doc: If I don't make it,
don't let my family anywhere near me...
Hagen Cartoons- http://www.hagencartoons.com

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Have you completed your own advance directives?

A recent survey of nearly 900 health care workers at a nonprofit Florida hospice found that fewer than half had completed advance directives.

Advance Directives

Advance Directives are legal documents that allow patients to state their wishes to healthcare providers, healthcare proxies and families about end-of-life care ahead of time to avoid confusion later on.

- Medical Power of Attorney
- Directive to Physicians and Family or Surrogates (Living Will)
- Out-of-Hospital Do Not Resuscitate (OOH-DNR) Order for Adults

Medical Power of Attorney

Who would you want to make medical decisions for you, if you were unable to make them for yourself?

- A **Medical Power of Attorney** (also called a **health care proxy** or a **health care agent**) is the person chosen to make health care decisions for a patient should that patient becomes unable to make decisions for themselves.

- A medical power of attorney can talk to doctors, consult medical records, and make decisions about tests, treatments, and other procedures.

Choosing a Medical Power of Attorney

- When is the right time to choose a medical power of attorney?
  - Age
- How often should one review this choice?
  - Major Life events
    - College
    - Marriage/Divorce
    - Medicare
    - New diagnosis or serious illness

Questions to Consider

Some important questions patients should ask when choosing a medical power of attorney:

- ✓ Will the person make decisions that are in line with my wishes, even if his or her own wishes are different from mine?
- ✓ Will the person be comfortable speaking up on my behalf to health care providers no matter the situation?
- ✓ Will the person be good at making decisions in changing circumstances?
- ✓ Will the person be able to make hard decisions?

Common questions healthcare providers may be asked about medical power of attorneys

- When does my medical power of attorney's responsibility begin?
- Can I choose more than one person to be my medical power of attorney?
- What if I don't want to pick my spouse or family member?
- Are there rules about who cannot legally be my medical power of attorney?
- What if I want to change my medical power of attorney?
- Do I need a lawyer to help me with this document?

Directive to Physicians and Family or Surrogates (Living Will)

What is it?

The Directive to Physicians and Family or Surrogates (DTP) is a legal document that allows you to direct physicians to administer or withdraw life-sustaining treatment when you have a terminal or irreversible condition and are unable to speak for yourself. You may also specify which treatments you would like, and which you would not.

What you should know:

- Decide for yourself what treatment you will and will not accept. Talk with your family, clergy and/or friends and then complete the document.

- A Directive to Physicians goes into effect only when you have a terminal or irreversible illness.

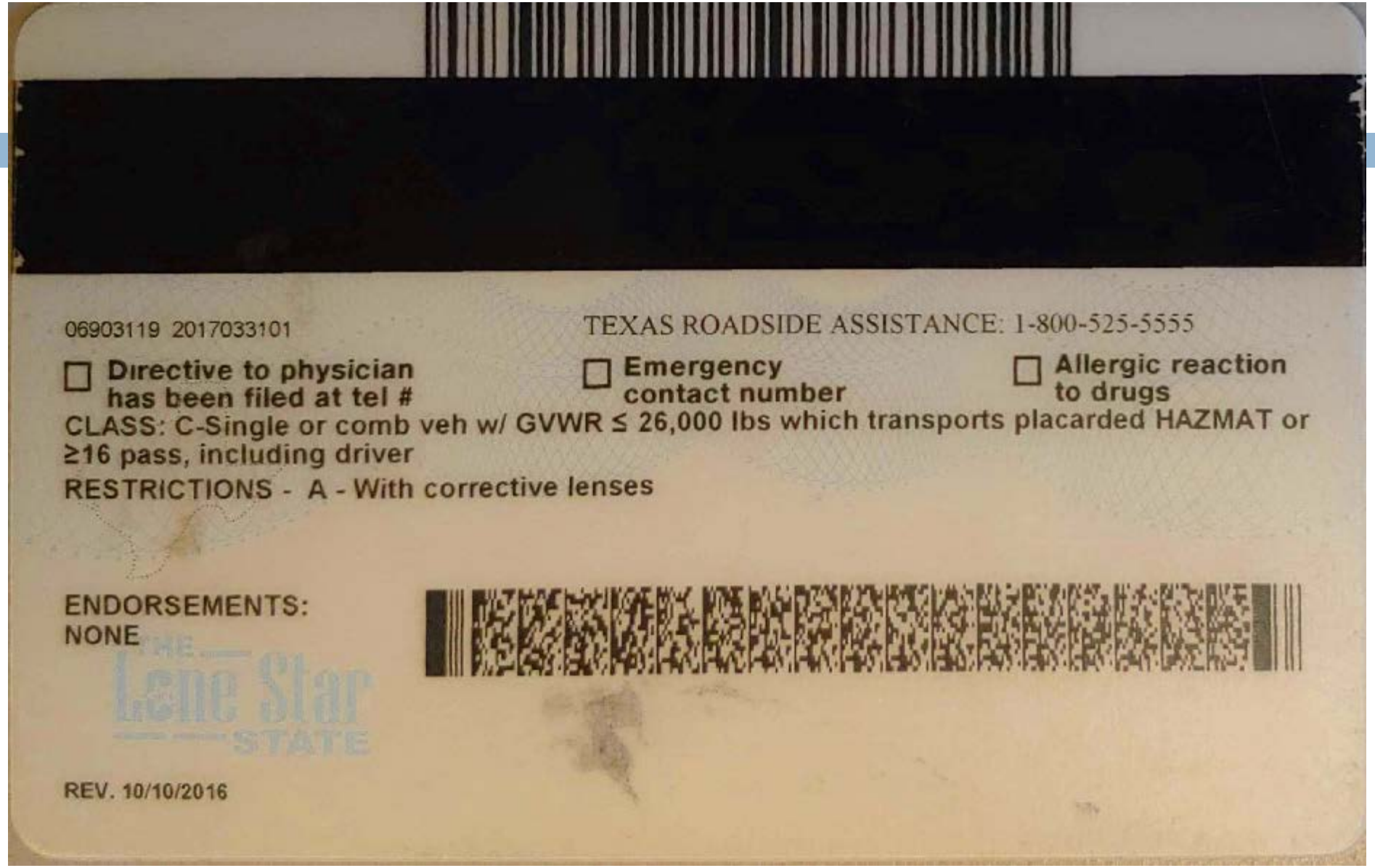
Out-of-Hospital Do-Not-Resuscitate Order

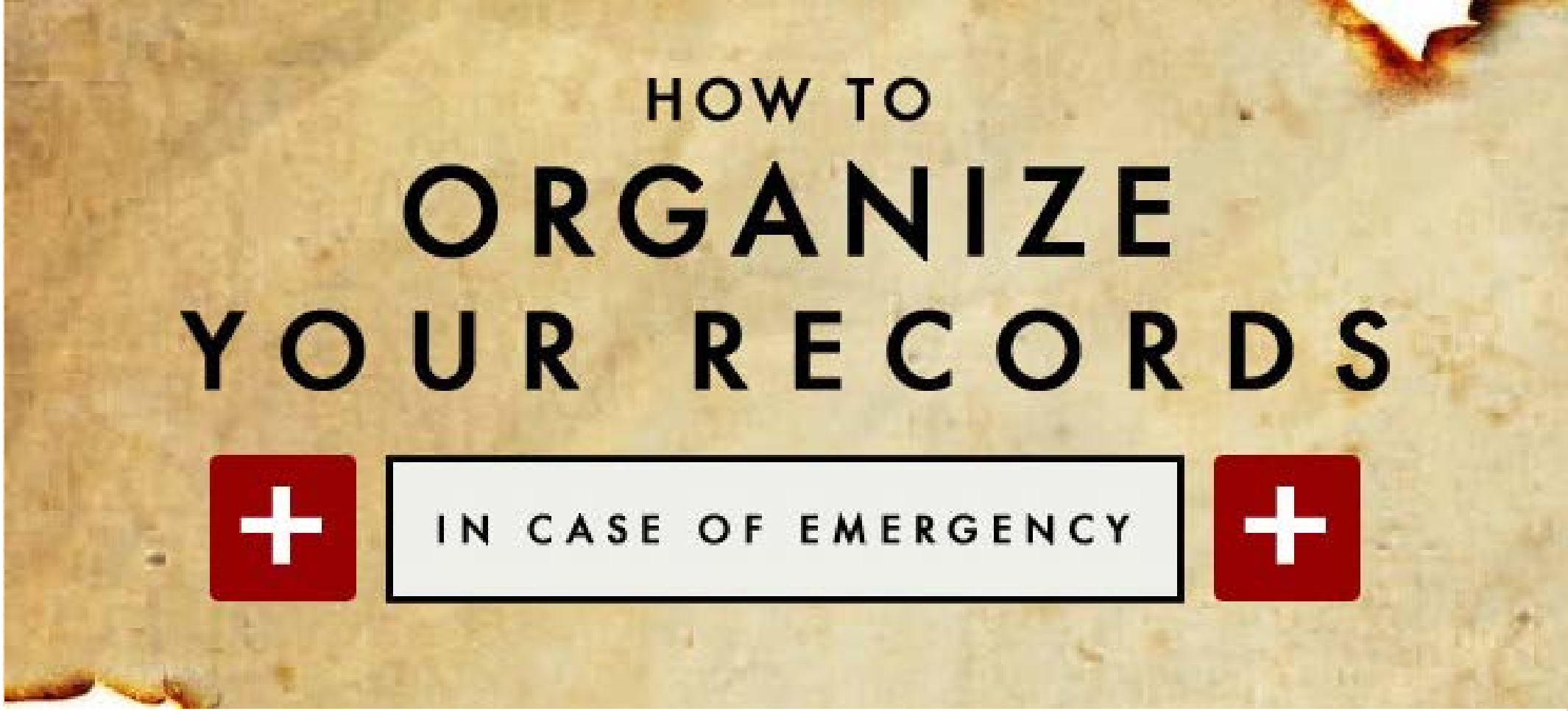
What is it?

The Out-of-Hospital Do-Not Resuscitate Order is a physician's order that tells health care and Emergency Medical Services (EMS) providers not to use specific medical interventions to try to revive you. This does not prevent medical interventions for comfort.

What you should know:

- EMS cannot honor this order unless it is signed by both you and your physician.
- If you are unable to complete this document, your Medical Power of Attorney or a qualified relative may complete it on your behalf.
- Once complete, post the Out-of-Hospital DNR Order in your home. Keep a copy with you and gives copies to your health care providers.


06903119 2017033101
TEXAS ROADSIDE ASSISTANCE: 1-800-525-5555
Directive to physician has been filed at tel #
Emergency contact number
Allergic reaction to drugs
CLASS: C-Single or comb veh w/ GVWR ≤ 26,000 lbs which transports placarded HAZMAT or ≥16 pass, including driver
RESTRICTIONS - A - With corrective lenses
ENDORSEMENTS:
NONE
THE Lone Star STATE
REV. 10/10/2016



Organizing Affairs Printable on Hospice Austin Website

https://www.hospiceaustin.org/news-information/advancedirectives/thegift/


easy

Completing Your Advance Directives

If you would like assistance completing your advance directives:

- The GIFT Project is hosting advance directive sessions from 12:00 – 1:00 pm on the first Thursday of every month at 4107 Spicewood Springs Road.

- If you've already had conversations with loved ones and are ready to complete your directives now, we can help you after this session.

Questions
Surveys
Presentations

Thank you for your time.

References

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The GIFT Project was made possible by a grant from St David's Foundation

For questions or to schedule a presentation, please contact:

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Visit www.HospiceAustin.org/AdvanceDirectives