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Challenges in the Clinic Setting

Limited time for unplanned discussions

Not something done frequently

A challenging topic to ease into

Can make individuals uncomfortable

Worried that patients will be pushed away



Normalize the Discussion

Make Advanced Care Planning a standard component of your workflow.

- Allows for routine discussion based on individual patient health status
- Creates an opportunity for PCPs to become more skilled in discussing advanced care planning
- Good advance care planning is an ongoing discussion throughout the lifespan of a patient

Create an opportunity to discuss Advanced Care Planning

- Patients expect us to start the discussion, specifically older patients
- Can deepen the relationship between PCP and patients
- Start small by sharing general information on advanced care planning



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Signposting and Scripting

Signposting

- A verbal que that helps to guide conversations.
- "I know you're here for your annual exam, but I'd also like to discuss something else as well towards the end of the visit."
- "At the beginning of our visit, I mentioned adding something to our discussion. I want
 to better understand the wishes of my patients, so I'm adding advanced care planning
 to every annual exam. Have you heard of advanced care planning before?"

Scripting

- Introduce advanced care planning
- Explain why advance care planning so important
- Acknowledge uncomfortable emotions
- Introduce the types of advanced care planning documents
- Provide printed materials for patients



Stages of Advanced Care Planning

First Stage

Most healthy adults

- Designate a healthcare power of attorney
- If I have a catastrophic event or accident or suffer a severe brain injury, what do I want my care to look like in this situation?

Second Stage

Adults with multiple comorbidities or a serious illness

- Develop a general "living will" applicable to patient's current condition
- If my condition becomes terminal, what type of care do I want to receive? Do I want all aggressive treatments, select treatment options, or comfort care measures only?

Third Stage

Older adults and those at high risk for a cardiac event

- Develop a "living will" based on current specific needs and create a DNR or LaPOST/MPOST if applicable
- If my heart stops, do I want CPR? If I am not able to eat or drink anything by mouth, do I want nutrition and hydration through an intravenous line?



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Advanced Care Planning Resources



FMOLHS Advance Care Planning Resources

https://fmolhs.org/services/advance-care-planning

Advance care planning resources and forms



Louisiana Health Care Quality Forum Initiative

Louisiana Physician Orders for Scope of Treatment & resources



Mississippi State Board of Medical Licensure https://www.msbml.ms.gov/node/122

Mississippi Physician Orders for Sustaining Treatment

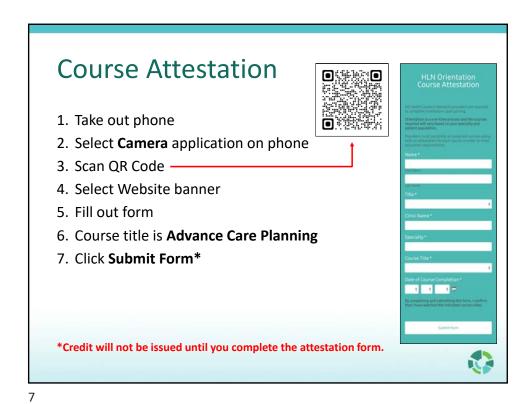


The Conversation Project

https://theconversationproject.org/

Public engagement initiative on end-of-life care





Coffee Talk with Dr Mark & Dr Mary

Episode 1

Episode 2

Episode 3

Episode 4