Health Leaders Network
Partnership for Population Health

Advanced Care Planning

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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

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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

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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
http://www.lhcqf.org/providers/resources
- 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

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Course Attestation

1. Take out phone
2. Select **Camera** application on phone
3. Scan QR Code
4. Select Website banner
5. Fill out form
6. Course title is **Advance Care Planning**
7. Click **Submit Form***

***Credit will not be issued until you complete the attestation form.**

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Coffee Talk with Dr Mark & Dr Mary

Episode 1

Episode 2

Episode 3

Episode 4

Education Attestation

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