Advance Care Planning: What’s the Physician’s Role?

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Objectives

- Define usual medical care vs palliative care vs hospice
- Discuss the physician’s role in helping make decisions in end of life planning
- Discuss the importance of patient centered care to advance care planning
Advance Care Planning
Who Should Be Doing ACP?
When Should ACP Be Done?
Why Do We Need To Do ACP?
DIFFERENT KINDS OF CARE

- Usual Medical Care
- Palliative Care
- Hospice Care
Usual Medical Care

• ICU care
• Procedures
• Testing
• Treatment
• Resuscitation
Palliative Care

- Comfort Care
- May include usual medical care
- May be limits
- Avoid nonbeneficial care or treatment
Hospice Care

- Comfort only
- Care focused in the home
- Minimize tests
- Focus on quality of life not prolonging life
How are different medical conditions involved

- CHF
- COPD
- Dementia
- Cancer
CHF - Usual Care

- Maximize medications for the heart
- Heart rehabilitation
- Left Ventricular Assist Device
- Heart catheterization
CHF – Palliative Care

- Maximize medication for the heart
- Encourage heart exercise
- Try different medications to help with breathing
- Decide whether returning to the hospital in the future makes sense
- Homecare
CHF – Hospice Care

- Care in the home or facility
- No returns to the hospital except for emergencies
- Comfort focus even if it results in death
- Quality vs quantity of life
COPD – Usual Care

• Maximize inhalers
• Stop smoking
• Nebulizers
• Exercise
• Transplant?
COPD – Palliative Care

- Maximize inhalers
- Stop smoking
- Nebulizers
- Encourage exercise
- Decide if returning to the hospital in the future makes sense (depends on the goals of care)
- Use medication to help with comfort/breathing

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COPD – Hospice Care

- Comfort focus
- No returns to the hospital
- Care in the home, facility or hospice house
- Medications including IV medication to help breathing, could cause sleepiness
Despite his parents' reassurances, Bill couldn't shake the nagging suspicion he might be adopted.
Dementia - Usual Care

- Evaluation by Neurologist or Geriatrician
- Memory clinic
- Medication for memory
- Independent living
Dementia – Palliative Care

- Medication for memory
- May need facility for living
- Plan for decreased independence and function (Bed bound more, memory loss, difficulty eating)
- Possible aspiration pneumonia, UTI, dehydration, bed sores
- Decide if returns to the hospital makes sense
Dementia – Hospice Care

- Comfort focus
- No returns to the hospital
- Eating for pleasure
- Does a feeding tube or IV fluids make sense (probably not!)
Cancer – Usual Care

- Depends on the stage/how advanced
- Chemotherapy
- Radiation therapy
- Surgery

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Cancer – Palliative Care

- Comfort always
- Even if cure is not an option, radiation or chemotherapy may help
- Goals of care discussions
- Does returning to the hospital make sense
Cancer – Hospice Care

- Comfort focus
- No more chemo or radiation
- Symptom treatment at home or at a facility for whatever time is left
- No returns to the hospital unless for emergencies
Patient Centered Care

What does this mean?
WHAT IS PATIENT CENTERED CARE?

Creating a community of care that ensures that each person's values and goals of care are expressed, understood, and honored.

Mark Ganz, JD CEO Cambia Health Situations
A Palliative Care Toolkit and Resource Guide
PATIENT CENTERED CARE- A PALLIATIVE PERSPECTIVE

Palliative Issues by Domain (appropriate for all patients?)

1) Pain and symptom management
2) Evaluation for anxiety and depression
3) Autonomy- Decision making capacity, understanding of current condition, advance directives
4) Coping and closure issues
5) Spiritual history
We need to meet patients and families where they are

Vs

making them meet us where we are
Goals of Care Template

Does the patient have an AD?

Is the patient decisional?

What is the patient’s code status and rationale?

What are the Goals of Care?
Goals of Care:
Date_______

1. Patient is decisional: (Yes/No)
   
   If not decisional: why?
   
   Comments (not all cases are yes/no)

2. Patient has completed an Adv Directive document(s)
   
   - None
   - WI POAHC
   - WI Living Will
   - Other:___________________________

   Is the AD in the chart: (Yes/No)

3. Code Status: ***
   
   Rationale behind code status: ***

4. Goals of care: ***
   
   a)
   b)
   c)
   d)
   
   As determined by:
   
   - Patient
   - Legal surrogate decision maker
   - Legal guardian
   - Other:___________________________
Goals of Care
Documentation Example

- Advance directives:
  - HCPOA in EMR; Daughter is POA. DNR/DNI; Rationale: Poor prognosis, family preference

- Decisionality:
  - Patient is not decisional

- Goals of Care:
  - 85 y/o with DM, dementia and weight loss, with new infection, possibly sepsis; patient very likely to die within 12 months. POA wants to try antibiotics and fluids to reverse infection.
Goals of Care Documentation Example

Â Goals of Care: POA does not want ICU admission or surgery. If patient deteriorates or does not improve within 48 hours the POA will consider shift to hospice care.

Â Plan: IV antibiotics for 48 hours then evaluate progress; daily POA updates.
Summary

- We need to meet patients where they are
- Encourage the conversation
- Know that there are options for our patients with serious and chronic medical conditions
- Advance care planning SHOULD be an emphasis for physicians
- Document, document, document