



# Proactive Advance Care Planning

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## Learning Objectives

**Common definition of Advance Care Planning & Framework**

Challenges with Advance Care Planning

Tools and resources for these discussions

Documenting

Answer Questions

# Advance Care Planning

Plans about FUTURE Health Care

Direction for Health Care Professionals *when the individual cannot direct*

1. Health Care Proxy
2. Advance Care Documents

## Our Patient

62 year old male with chronic conditions of DM, COPD, on home oxygen and has CKD stage 2.

Seeing him in outpatient setting, either video-visit or in person depending on your practice setting.

# The Challenge

Bringing up the topic of Advance Care Planning

INTERNAL: Shift from talking in crisis or chaotic situations to calmer ones.

EXTERNAL: Normalize the practice in OUTPATIENT setting where clinician who knows the patient is having these discussions.

## CALMER mnemonic

C: Check IN

A: Ask about Advance Directives

L: Lay out issues

M: Motivate then to choose a proxy & talk about what matters most

E: Expect emotion

R: Record the Discussion

## CALMER: Check In

Requires time allotment in your visit and proactively plan.

Creates the space.

Check emotional temperature of the patient and NORMALIZE discussion.

I would like to spend some time on an important topic.

## CALMER: Ask About Advance Directives

What do you know about Advance Care Planning?

By introducing the topic and inquiring their knowledge, you can gauge both their willingness and their knowledge.

If no knowledge or awareness, brief visit this time with plan for longer one next time:

I'd like you to think about some things for next time.

Who would you like to speak on your behalf if you are unable.

What matters most you?

Give them information about Advance Directives.

## CALMER: Ask About Advance Directives

If they have considerable knowledge or awareness, or this is the follow-up from last time.

Who would you like to speak on your behalf if you are not able?

What are your wishes, preference and limits? Are your loved ones aware?

In asking these questions and allowing the patient time to think about them (maybe in between visits) you allow for more meaningful discussions.

## CALMER: Lay Out Issues

With your health issues, I want to make sure everyone who takes care of you knows we have had these discussions.

I want them to know YOUR values.

I want them to know YOUR preferences.

I want them to know YOUR limits.

By personalizing that the decisions are theirs, we are empowering them to think in advance.

## CALMER: Lay Out Issues

Normalize the proactive discussion.

Advance Care Planning is like other types of planning or insurance. It is there for the “what ifs” and needs to be set before the situation happens (like a car accident).

## CALMER: Motivate them to make decisions.

Motivate decision making

- 1) proxy
- 2) what matters most

Normalize that having SOMETHING as a base is important.

Normalize that it can be changed at ANYTIME in the future.

THIS is the time your worries for them.

IF no proxy, decision maker is the LNOK

IF no discussion, it will be the crisis discussion in hospital by strangers.

## CALMER: Motivate them to make decisions.

IF things took a turn for the worse, what you say now can help your family/loved ones?

Who is your back-up person? Who helps us make decisions if you cannot speak for yourself? Who else?

When your health worsens, what are your important goals?

Biggest fears and worries?

Abilities so critical you cannot imagine living without them?

How much are you willing to go through for the possibility of more time?

How much does your family/loved ones know?

## CALMER: Expect Emotion

These topics can evoke lots of emotions.

Clinicians do NOT like emotion and they do not know what to do with it

WE can do harm by ignoring it.

Most humans need to be seen, heard and felt understood.

IF emotion comes out, make them FEEL seen, heard and understood.

HOW?

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HOW?

## CALMER: Record the discussion.

Let's talk about the documentation:

This is very EMR (electronic medical record) dependent.

This is very STATE dependent.

Generally, 1<sup>st</sup> step is writing it down, in progress note or an ACP tab, documents and allows you to bill for the work done.

2<sup>nd</sup> step/key to of documentation is the ease of access for future providers.

Some states require HPOA (health care power of attorney) paperwork and documentation to be witnessed.



## CALMER: Record the discussion.

Documentation can also be thought of as INTERNAL and EXTERNAL.

Internal includes:

1. Documentation for billing
2. Documentation for future providers

External includes paperwork that belongs to the patient.

All original documents should be retained with patient. Copies may enter our EMR, but they should travel with patient.

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## Challenges: Bringing it up

Hopefully the CALMER framework will help.

Question 1: Are you familiar with Advance Care Planning?

Yes: continue

No: give information and reschedule

## Challenge: Choosing a Proxy

Most patients do not understand that choosing a proxy is an empowerment tool.

Question 2: Who is your proxy?

It is our job to give them context. Not guide their decision.

Your proxy is the person you designate us to call if you are not able to speak and make your health care decisions. It can be anyone you choose.

Help them pick more than one proxy.

Who else? If your first pick is not available, who else is on that list.

## Challenge: Choosing a Proxy

Inform them of the status quo if they do NOT choose one.

Sometimes, motivation can be as much avoiding an outcome than electing an option.

Without a health care power of attorney, your decision maker is your legal next of kin (so define the power of surrogate).

Inform them that electing a health care proxy helps future clinicians who do not know their family situations.

This tells everyone who will ever take care of you in the future (can list ambulance drivers, ER doctors, etc) that you and I discussed your trusted health care decision makers.

## Challenge: What are Advance Directives

So, you may have noticed that I have NOT discussed code status.

Advance Care Directives are NOT code status (alone).

Not by definition.

They tend to be about code status by action, when we have those crisis discussion (before someone crashes) or chaotic ones (by unfamiliar providers).

Why we are redefining as CALMER discussions.

## Challenge: What are Advance Directives

Advance Care Documents: Document detailing an individual's health care preferences.

They can be formal or less formal but generally is a Living Will

Code status is a PORTION of the Living Will (it is really a sophisticated limit of treatments).

MANY types of these are tools that are better patient language.

These are not PREFERRED documents, because they bring medical decision making to patients for future morbidity.

## Challenge: Provider Discomfort

These are not easy conversations to have.

Recognize this is the first step. Using scripts and frameworks until they are more routine practice.

Shifting the focus of the conversation to preventative calmer discussions in the outpatient setting with known/trusted providers will make them easier discussions to keep having; routine practice.

HAVING them will prime the patient/family for later ones that inpatient providers might need to have (crisis/chaotic ones). These may be less traumatic on patients as they will be familiar topics.

## Challenge: The terms.

Health Care Power of Attorney or Durable Power of Attorney for Health Care are every legal terms.

MANY abbreviations and synonyms for similar terms.

proxy

surrogate

HPOA

DPOA

Health Care Agent

## Challenge: Others

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# Tools and Resources:

State of Ohio (or your state) has a repository of Advance Care Planning preferred documentation.

Many are free downloads and do NOT require legal representation.

Physicians are NOT necessary to initiate process.

## Tools and Resources:

Inquiry about whether patient knows about Advance Directives can be part of the intake.

IF they answer NO, the intake personnel can give the printed fact sheets.

Can schedule longer appointment for future visit and you merely mention:

I see that you have received information about Advance Directives. These are very important aspect of your care. Let's set aside time next visit for more discussion.

## Tools and Resources:

<https://fivewishes.org/>

<https://theconversationproject.org/>

<https://www.cdc.gov/aging/pdf/acp-resources-public.pdf>

<https://www.nia.nih.gov/health/caregiving/advance-care-planning>

<https://acpdecisions.org/advance-care-planning-guide-part-2-list-of-resources%E2%80%9F/>

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# Documenting:

## Documenting

Like advance directives, documenting ANYTHING is better than no documentation.

Some folks cannot make those proactive decisions. Documenting efforts made helps the next person.

It can be a starting point. “I see that Dr. Smith has talked with you in outpatient...”



## Documenting:

Like advance directives, documenting ANYTHING is better than no documentation. Some folks cannot make those proactive decisions. Documenting efforts made helps the next person.

It can be a starting point. "I see that Dr. Smith has talked with you in outpatient..."

Please document that you have had conversation even if the decision hasn't been made or patient does not agree with you./

I have spoken to Mr. Jones about my recommendations for both electing a health care proxy and completion of Living Will. I have further recommended Do Not Resuscitate as he has told me long-term supports with his advanced COPD is not desired.

He is thinking about these recommendations and we will readdress at next visit.

## Documenting:

IF you achieve either (election of proxy and Living Will) then simply upload into EMR along with your note.

You may fill out DNR form and upload copy (original is property of patient).

There are exciting ACP smart phrase and templated to walk you through these discussions as well.

## Our Patient

62 year old male with chronic conditions of DM, COPD, on home oxygen and has CKD stage 2.

Goals: to be independent

Fears/Worries: living in a NH

Limits: machines like dialysis are okay if I can stay independent. I do not want to be hooked up to machines that are keeping me going if I cannot enjoy my family.

Code status: everything that will help me be independent

Proxy: my baby daughter. She is a RN and she is sensible and not selfish.

## Documenting:

Spoke with Mr. Jones about his wishes.

He has elected his youngest daughter as his health care proxy (insert name) and his older daughter and wife as his 1<sup>st</sup> and 2<sup>nd</sup> alternative.

He has voiced some preferences about ongoing care including hemodialysis and resuscitation, both of which are acceptable if they return him to free and autonomous function.

Health Care Proxy Paperwork Completed and uploaded into EMR; original given to patient.

Living Will given to patient and he will complete and bring back to next visit.

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