

Advance Care Planning Fact Sheet

Empowering Patients to Prepare for Future Care

Advance care planning (ACP) involves a face-to-face discussion between a physician or other qualified healthcare professional and a patient about the patient's wishes for future medical treatment and care. It includes possible physician assistance with completing related forms, including advance directives.

The Forms

Advance directives are state-recognized documents that detail the patient's instructions for end-of-life care. The two main types of advance directives are a living will and a healthcare power of attorney.

A **living will**, or declaration, specifies decisions concerning medical care in the event the patient becomes physically or mentally unable to communicate.

A **healthcare power of attorney** designates someone to make medical decisions on the patient's behalf. Patients may need to speak with an attorney for advice on creating one specific to their needs.

You or your Peoples Health patients can download the Louisiana Advance Directives booklet from <http://www.peopleshealth.com/advancecareplanning>. The booklet includes a living will document, and it is distributed to all new Peoples Health plan members.

Louisiana Physician Orders for Scope of Treatment, commonly referred to as LaPOST, is a document that establishes medical orders instructing healthcare providers on whether to administer certain life-sustaining measures in the event of a medical emergency. It is specifically for patients with serious, advanced illnesses, and to be valid it must be signed by a physician and the patient or the patient's power of attorney.

Copies of these forms are included in this toolkit and are available on the Provider Portal.

Why is it important to talk with your patients about ACP?

- » Nine out of 10 Americans think it's important to discuss their end-of-life wishes, but just over 25 percent do.*
- » Sixty-five to 75 percent of doctors aren't aware that their patients have end-of-life wishes.*
- » Research shows that 90 percent of adults say they would prefer to receive end-of-life care in the home, yet only about one-third of Medicare beneficiaries, ages 65 and older, die at home.†
- » Medicare is the largest insurer of healthcare during a patient's final year of life. It spends \$50 billion annually during the last two months of a patient's life.*

*Atul Gawande, M.D., MPH and Robert Bessler, M.D., "Being Mortal: Medicine and What Matters in the End" (webinar, Sept. 16, 2015).

†The Henry J. Kaiser Family Foundation website; accessed 02/23/16; http://kff.org/medicare/fact-sheet/10-faqs-medicares-role-in-end-of-life-care/#endnote_link_153315-3; "10 FAQs: Medicare's Role in End-of-Life Care."





The Discussion and the Approach

ACP discussions are best had before a patient's illness progresses or during early treatment, and they can occur during any appointment. As wishes can evolve over time, encourage regular discussion, at least once per year during your patients' annual wellness visit.

Knowing what's important to your patients may allow for more focused care.

- » **GAUGE** how much patients want to know about their conditions.
- » **EDUCATE** patients on their options. Discuss not only which treatments can extend life, but those that would help the patient meet certain goals, even if the options are for comfort care.
- » **FIND OUT** the extent of what patients are willing to go through to get what they want. In some cases, patients may live longer when no drastic measures are taken.
- » **HAVE** a series of discussions if needed, because advance directives are dynamic. Some patients may be sure of their choices; others need more guidance or may change their minds over time.
- » **INVOLVE** family, because when family isn't involved, they are ill-prepared to be end-of-life decision makers.

Per the research paper, **Communication about serious illness care goals: a review and synthesis of best practices** (<http://www.ncbi.nlm.nih.gov/pubmed/25330167>), "...best practices in discussing goals of care include the following: sharing prognostic information, eliciting decision-making preferences, understanding fears and goals, exploring views on trade-offs and impaired function, and wishes for family involvement."

Sharing Advance Directives

Following an advance care planning discussion you conduct with a Peoples Health patient, we may reach out to the patient to offer additional planning tools or guidance as needed.

Any advance directives that we receive from your Peoples Health patients will be available in Member Viewer under the Member tab, and we ensure a copy is available to the patient's healthcare providers as needed. Please encourage your patients to share their advance directives with their healthcare providers, family and caregivers. Additionally, we ask that providers share with us any advance directives they receive for their Peoples Health patients. Fax advance directives to 504-849-6906, or mail a copy to Attn: Member Services, Peoples Health, Three Lakeway Center, 3838 N. Causeway Blvd., Suite 2200, Metairie, LA 70002. The goal is to ensure that all the patient's healthcare providers, including hospitals, have access to the advance directives as needed.

The words you use matter. As author, surgeon and researcher Atul Gawande states in *Being Mortal: Medicine and What Matters in the End*:

According to palliative specialists, you shouldn't say, "I'm sorry things turned out this way," for example. It can sound like you're distancing yourself. You should say, "I wish things were different." You don't ask, "What do you want when you are dying?" You ask, "If time becomes short, what is most important to you?"

For seven key questions to ask during a patient conversation, reference the Serious Illness Conversation Guide included in this toolkit.

For more information, including ACP resources, visit the Provider Portal or contact your provider representative at:

504-849-4500
225-346-6380
1-800-631-8443

Monday through Friday,
from 8 a.m. to 5 p.m.