The Truth about Advance Care Planning and Palliative Care

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Palliative Care Clinical Nurse Specialist

Palliative

Objectives

- Define Advance Care Planning (ACP).
- Acknowledge the continuum and factors in the ACP process.
- Recognize the professional role in the ACP continuum.
- Identify strategies for incorporating palliative care.
- Explain what/where your role is in palliative care.

Myths about ACP

My loved ones will know what I want when the time comes.

I need a lawyer to create an advance healthcare directive.

An advance directive only matters if I put it in writing.

Once I put my plans in writing, I can’t change them.

If I name a health care agent/proxy, I give up the right to make my own decisions.

Myths about ACP (cont)

You must have a living will to stop treatment near the end of life.

You have to use your state's statutory form for your advance directive to be valid.

Advance directives are legally binding, so doctors have to follow them.

An advance directive means "Do not treat."

I should wait until I am sure about what I want before signing an advance directive.

Myths (cont)

Just talking to my doctor and family about what I want is not legally effective.

Once I give my doctor a signed copy of my directive, my task is done!

If I am living at home and my advance directive says I don’t want to be resuscitated, EMS will not resuscitate me if I go into cardiac arrest.

Advance directives are only for people who are old and sick.

What is Advance Care Planning (ACP)

- A process of communication between a patient, family/health care proxy/decision-maker, and/or healthcare professionals to clarify treatment preferences and to develop goals of future healthcare.

- The goal is to ensure people receive the medical care and treatment that is consistent with their values, goals and wishes during serious or chronic illness.

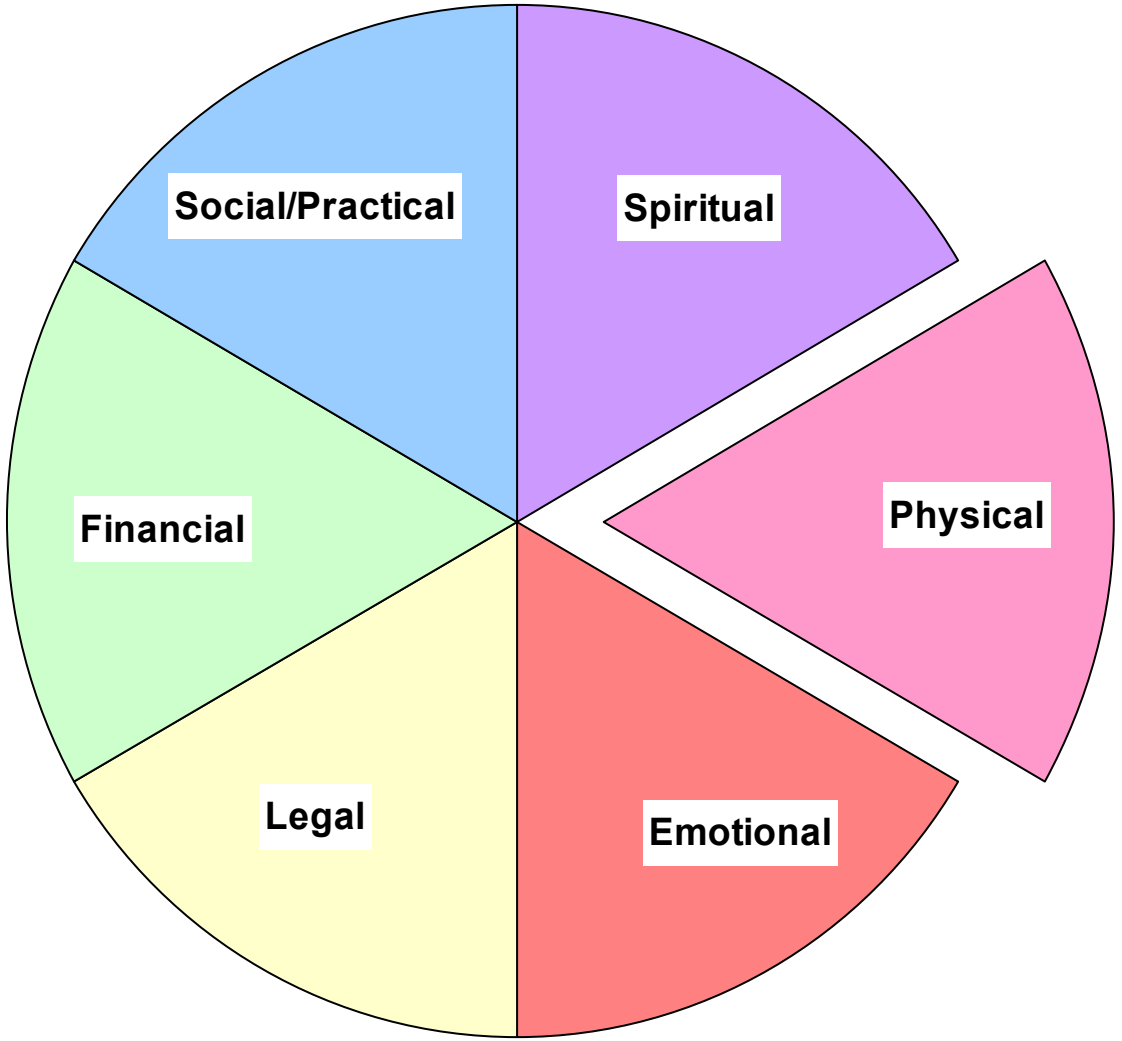
The Role of Advance Care Planning in Long-Term Care Facilities (LTCFs

Empowers	Empowering Residents
Improves	Improving Care Concordance
Reduces	Reducing Hospital Admissions
Enhances	Enhancing Family Support
Addresses	Addressing Common Barriers

Advance Care Planning

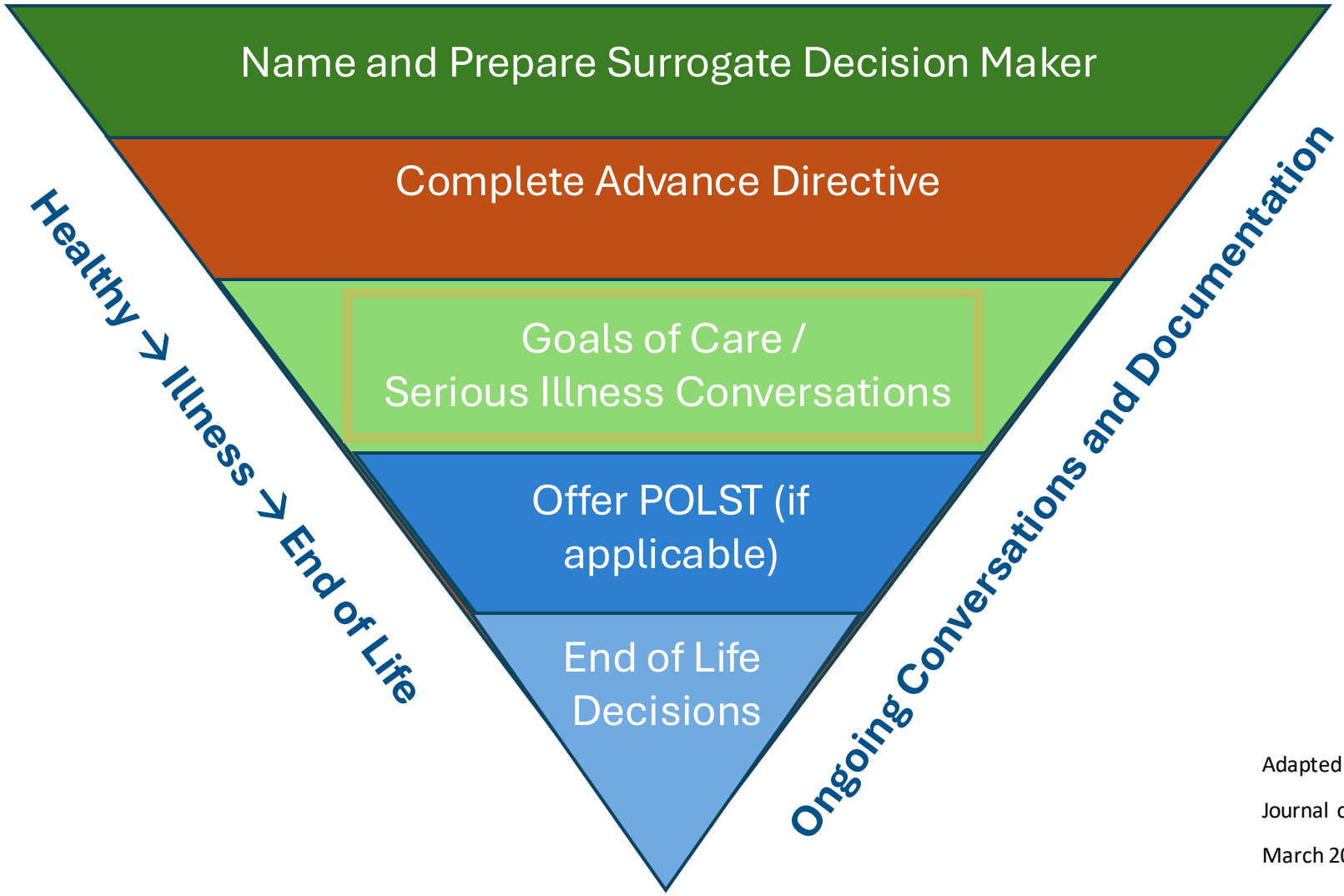
Whole Person Planning

MOLST
MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT
A POLST Paradigm Program



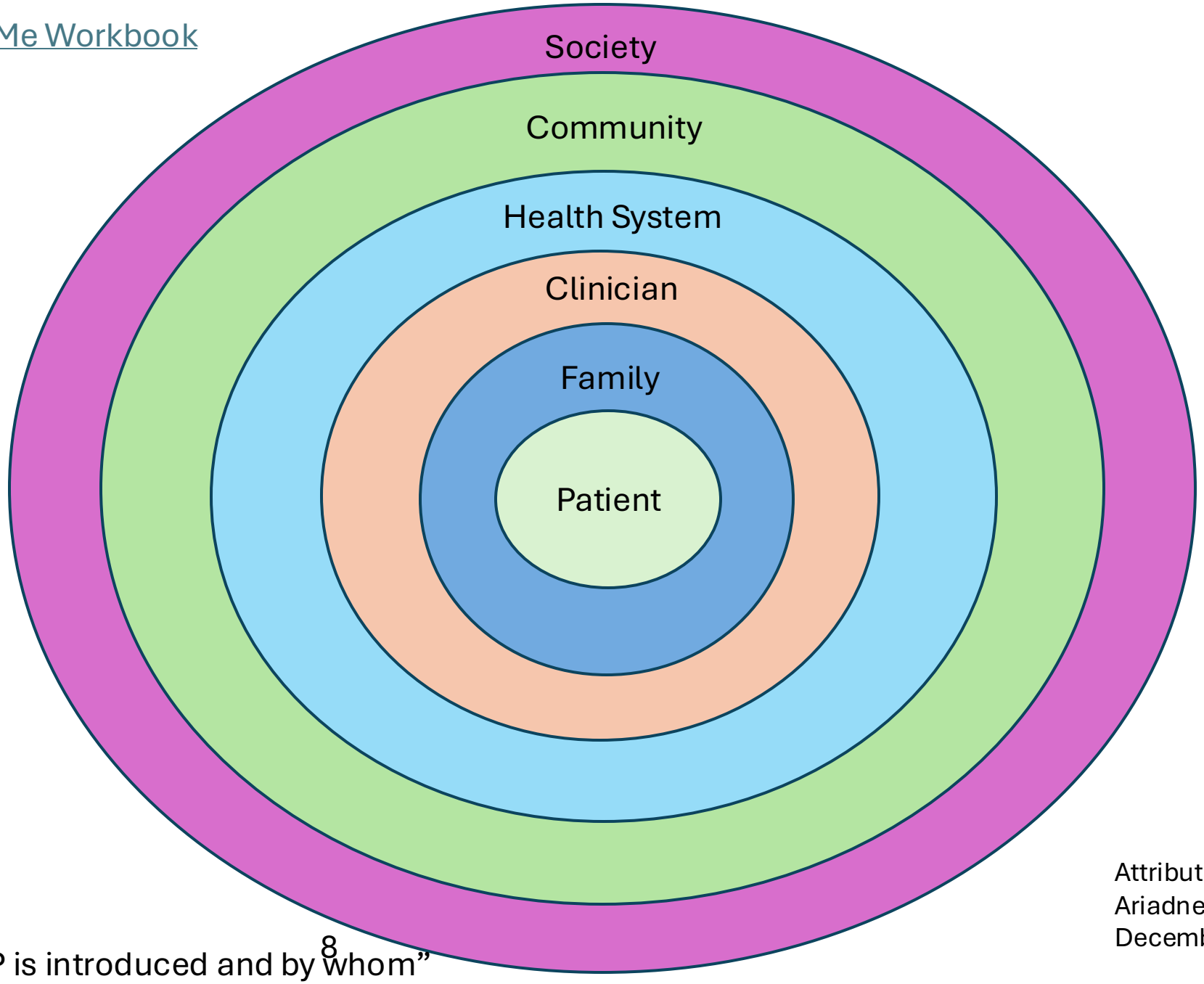
Compassion and Support at the End of Life

Continuum of Advance Care Planning



Adapted from: Izumi S and Fromme EK, Journal of Palliative Medicine. March 2017, 20(3): 220-221.

What Matters to Me Workbook



Attribution to Dr Erik Fromme, Ariadne Labs presentation, December 19,2021

“It matters how ACP is introduced and by whom”

Benefits of Advance Care Planning

- Gift to the Family
- Gift to the Healthcare Team
- Promotes patient-centered care
- Helps ensure patients receive the care they want
- Reduces the decisional burden of families
- Enhances patient and family satisfaction
- Positively impacts quality of life and end-of –life care
- Promotes higher completion rates of advance directives
- Improves conversations between patients, families and healthcare team

Advantages to Advance Care Planning (cont.)

Reduce the chances of dying in the hospital
Decreases cost of care
Improve compliance of end-of-life wishes
Improve patient and their families' satisfaction with care
Reduces family stress
Reduces anxiety and depression
Improves care at the end-of-life

Communication Needs of the Resident

“ I don't know what I don't know”

- Information for informed choices
- Simplify information
- Disclosure of feelings
- Verbalization of fears
- Sense of control
- Discussion about the meaning of life
- Maintaining hope
- Reassurance of pain and symptom management

Communication Needs of the Family

- To be with their loved one
- Information and frequent updates
- Permission to speak and be listened to
- To be heard
- Aware of changes in the patient's condition
- Assurance of comfort
- Open and honest communication
- Provided a safe space

Resident and Family Expectations

- Build rapport
- Be honest
- Illicit values and goals
- Keep patient and family informed
- Communicate with the team
- Take time to listen
- Provide a safe space

If You Don’t Ask- You Won’t Know

Assess vs Assume:

- Social determinants of health
- Culture determinants
- Spiritual determinants

Goal:

A sense of belonging
and interconnectedness

Key Discussion Components in ACP

- Health Care Proxy
- Living Will
- DNR and DNI orders
- Goals of Care
- Cultural and Spiritual Considerations

Challenges in LTC

Staff Issues

- Staff discomfort
- Timing
- Training
- Fragmented care

Resident Issues

- Family dynamics
- Communication barriers
- Cognitive impairment

Eliciting Values

“ I want to find out What Matters Most”

- Connecting with others
- Enjoying life
- Maintaining Health
- Functioning

Communication and Goals of Care

- Patient’s wishes, preferences
- Goals of Care Planning
- Code Level Discussion
- POLST
- Resuscitative Statistics
- Healthcare Directives

Key ACP Strategies in LTCF

- Normalize ACP
- Be their advocate
- Establish trust
- Right setting and timing
- Focus on values and goals (not just documents)
- Use tailored communication methods- open ended questions
- Focus on their unique individual wishes
- Allow for repeated discussions

Team-Based Strategies

- Implement a whole-ward/system approach
- Designate ACP facilitators or "champions”
- Standardize the ACP process
- Ensure management buy-in
- Provide staff training and emotional support

Tools to Get Started
Ice Breakers

- Go Wish Game (next slide)
- Serious Illness Messaging (discussed)
- Hard Choices For Loving People by Hank Dunn

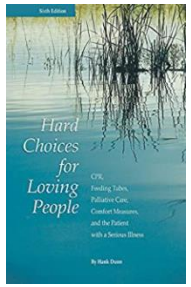
Considering the goals of medical care before making healthcare decisions

Common medical treatment decisions for seriously ill patients, such as

CPR, feeding tubes, dialysis, pacemakers and implanted defibrillators, hospitalization,

palliative care, and hospice care

The emotional and spiritual concerns at the end of life for people of any or no faith tradition

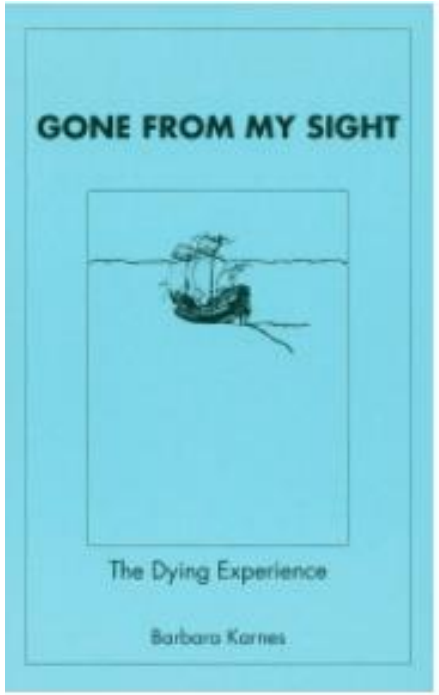


The Conversation Project Starter Kit

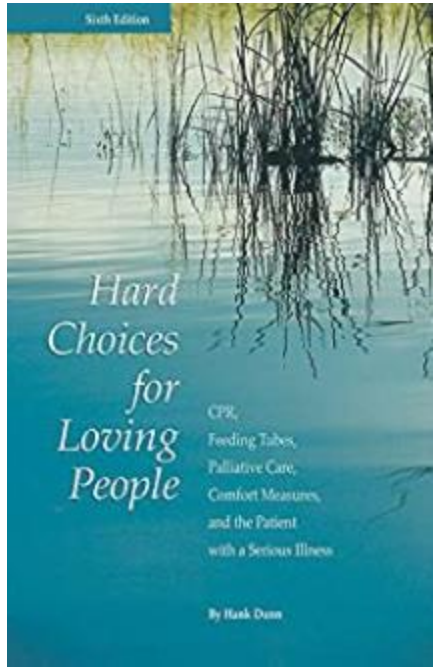
- Healthcare Agent
- Talking to Doctor
- Serious illness
- Dementia
- Pediatrics
- COVID-19

How Much Can We Share?

- What is their understanding
- What do they want to know- how much?
- Team approach
- Generalization
- Neutral value
- Story Telling
- Scope of Practice



Gone From My Sight: The Dying Experience



Hard Choices for Loving People: CPR, Feeding Tubes, Palliative Care, Comfort Measures, and the Patient with a Serious Illness, 6th Ed. Paperback – April 24, 2016

Different Names for Advance Directives

- Health Care Directive (North Dakota Century Code)
- Living Will
- Personal Directive
- Medical Directive
- Advance Decision
- Mental Health Advance Directive

What is a Healthcare Agent?

A healthcare agent is an individual that is appointed to make healthcare decisions if the patient is unable to communicate medical preferences

A healthcare agent may also be referred to as:

- A healthcare proxy
- A power of attorney for healthcare
- Surrogate decision-maker

Different Names for the Health Care Agent

- Health Care Proxy/Agent
- Medical Power of Attorney (POA)
- Healthcare Power of Attorney (POA)
- Health Care Attorney-in-Fact
- Health Care Representative
- Health Care Surrogate
- Surrogate Decision Maker
- Guardian and Conservator

When to Review Health Care Directives

The American Bar Association encourage clients (patients) to revisit their advance directives and legal documents whenever any of the ”six Ds” occur:

- You reach a new **DECADE** in age;
- You experience the **DEATH** of a loved one;
- You experience a **DIVORCE**;
- You receive a **DIAGNOSIS** of a significant health condition;
- You experience a significant **DECLINE** in your functional condition; and
- You change your **DOMICILE** or someone moves in with you

(Sabatino & Arkfeld, 2019, p. 56))

Explain Default Policy

“It is very important that you understand that it is our policy is always to provide all life sustaining treatments for any person that has not told us that there are treatments that they do not want.”

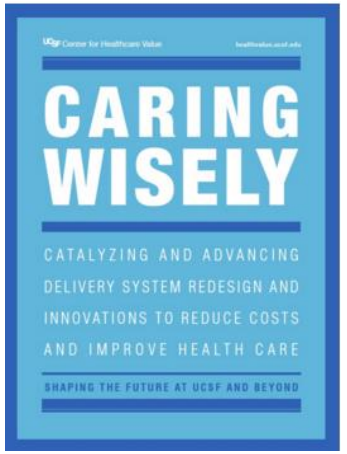
https://polst.org/advance-care-plans/

Giving Choices

- Aggressive Treatment
- Time limited goals
- Comfort focus including hospice from the beginning
- Life sustaining treatment

Choosing Wisely®

An initiative of the ABIM Foundation



Centering Treatment on Patient's Needs and Preferences- "What Matters"

- Results of Patient Family Questions
- Serious Illness Conversation Guide
- Health Literacy
- As a healthcare consumer
- Documentation/Communication across services / disciplines
- Coordination and transition services

Identify Helpful vs. Bothersome/Unwanted “Care”

- Medications
- Tests
- Treatments
- Procedures

Non-beneficial treatment (NBT)

An objective inverse correlation between intensity of treatment and the expected degree of

- **Treatment** is medically non-beneficial because it offers no reasonable hope of recovery or improvement, or because the patient is permanently unable to experience any benefit.
- **Treatments** that offer no physiological benefits to the patient are **futile**
- **Care and Comfort are ALWAYS Possible**

Treatments to Prolong Life in Advanced Illness

- Code Status: Attempt CPR or Allow Natural Death/DNR
- Ventilators
- Dialysis
- Medically assisted nutrition

Resources for Families:

- Hard Choices for Loving People
- Family Caregiver Alliance website
    - Advanced Illness: Holding On and Letting Go

Medical Battery vs Good Samaritan Law

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a ‘surgeon’ who performs an ‘operation’ without his patient's consent **commits an assault**, for which he is liable in damages.”

Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). 20 Pa C.S. §§ 5422 through 5488 (2010)

Documentation and communication strategies

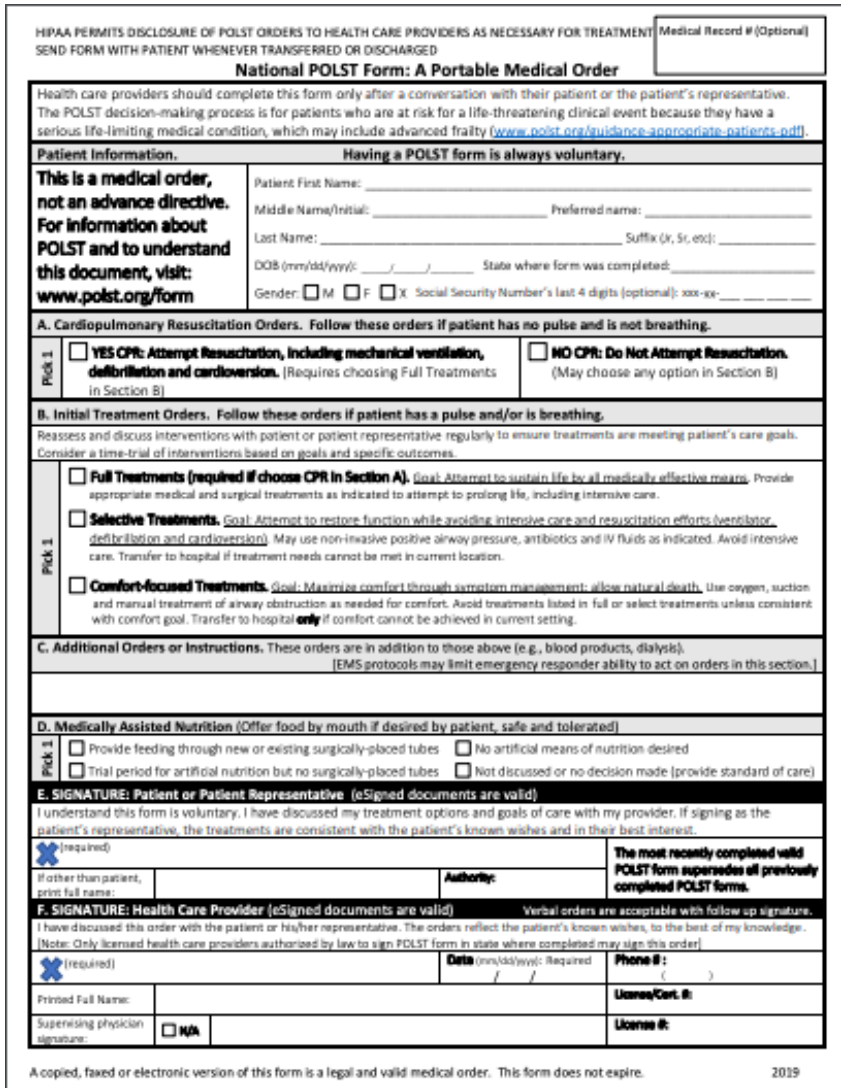
Document and transfer	**Document and transfer information effectively**
Leverage	**Leverage existing programs and visits**
Use	**Use technology for efficiency and access**
Communicate	**Communicate with family and PCP**

What is POLST?

A process. Part of advance care planning- A National Paradigm, state program and medical order completion

Conversation. Risks, benefits, burdens, expected outcomes, patient preferences

A medical order form that travels across settings



HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____
Middle Name/Initial: _____ Preferred name: _____
Last Name: _____ Suffix (Jr, Sr, etc): _____
DOB (mm/dd/yyyy): ____/____/____ State where form was completed: _____
Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-__ __ __ __

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired
☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Not discussed or no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required) | If other than patient, print full name: | **Authority:**

The most recently completed valid POLST form supersedes all previously completed POLST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) — Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) | **Date** (mm/dd/yyyy): Required ___/___/___ | **Phone #:** (___) ___

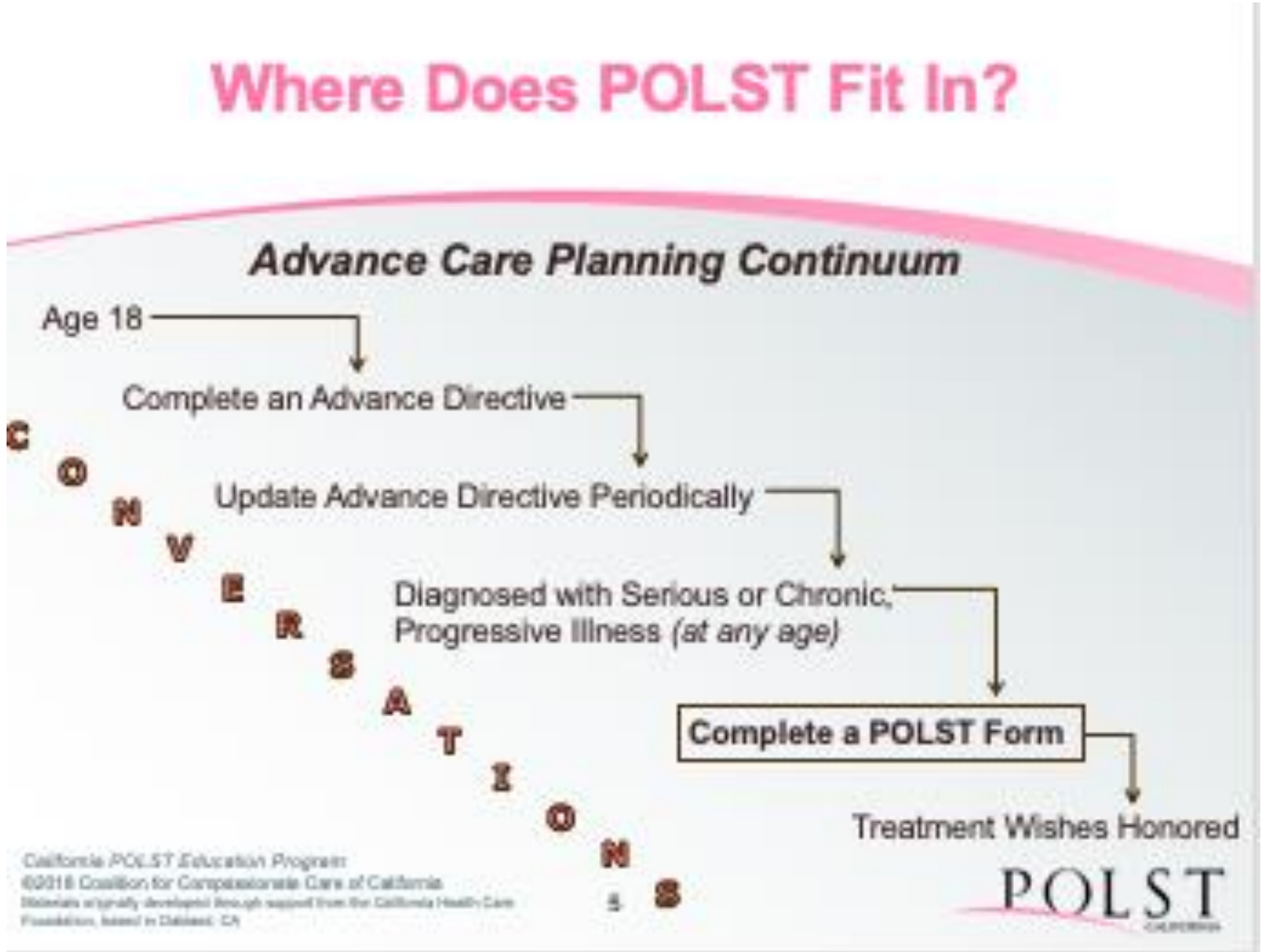
Printed Full Name: | **License/Cert. #:**

Supervising physician signature: ☐ N/A | **License #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

Honoring the wishes of those with serious illness and frailty.

Where Does POLST Fit In?



Comparing POLST Form to Healthcare Directive

	Healthcare Directive	POLST Paradigm Forms
Population	All adults >18 y.o.	Any age, serious illness, at end of life or frailty
Time Frame	Future care/future conditions	Current care/current conditions
Where Completed	Any setting, not necessarily medical	Medical setting
Resulting Product	Healthcare agent appointed and/or statement of preferences	Medical orders based on shared decision making
Healthcare Agent Role	Cannot complete	Can consent if patient lacks capacity
EMS Role	Does not guide EMS	Guides EMS as a medical order
Portability	Patient/Family Responsibility	Healthcare Professional Responsibility
Periodic Review	Patient/Family Responsibility	Healthcare Professional Responsibility

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

North Dakota POLST: Physician Orders for Life Sustaining Treatment

Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, THEN Call the appropriate medical contact. These medical orders are based on the patient's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name

Patient's First Name/Middle Initial

Patient's Date of Birth (mm/dd/yyyy)

A — Check One

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **CPR/ATTEMPT RESUSCITATION** ☐ **DNR/DO NOT ATTEMPT RESUSCITATION** (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C.

B — Check One

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

Comfort Measures always provided regardless of level of care chosen.

☐ **COMFORT MEASURES ONLY -** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

- ☐ Avoid calling 911, call _____ instead (e.g. hospice)
- ☐ If possible, do not transport to ER (when patient can be made comfortable at residence)
- ☐ If possible, do not admit to the hospital from ER (e.g. when patient can be made comfortable at residence)

☐ **LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS -** Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions. In addition to treatment described in Comfort-Measures Only, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Duration of invasive or uncomfortable interventions should be limited. (Generally, avoid intensive care)

☐ **FULL TREATMENT -** Use all appropriate medical and surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care.

Additional Orders: (e.g. dialysis, etc.)

C — Check One

Artificially Administered Fluids and Nutrition: Always offer food/fluids by mouth if feasible and desired.

Check One

- ☐ No artificial nutrition by tube.
- ☐ Defined trial period of artificial nutrition by tube.
- ☐ Artificial nutrition and hydration unless it provides no benefit.
- ☐ Long-term artificial nutrition by tube.

Additional Orders:

D — Must fill out

DOCUMENTATION OF DISCUSSION (Required)

☐ Patient (if patient has capacity)

If patient lacks capacity:

- ☐ A Health Care Directive
- ☐ Health Care Agent
- ☐ Person legally authorized to provide informed consent (See reverse)

Health Care Agent/Legal Representative Name — Relationship

E

PATIENT or Health Care Agent/Legal Representative (Required)

Signature — (Form Does Not Expire) Date of signature

F

ATTESTATION OF MD/DO/APRN/PA (Required) By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's current medical condition and preferences.

Print Name of MD/DO/APRN/PA Name — Signer Phone Number — Signer License Number

MD/DO/PRN/PA Signature: required — Date: required — Time: required

Myths about Palliative Care

Palliative care is:

- Hospice or end-of-life care
- Based on prognosis
- Just for people with cancer
- Giving up
- Just about pain management
- Only for adults
- Only for the patient, not the family

Palliative Care Myths (cont)

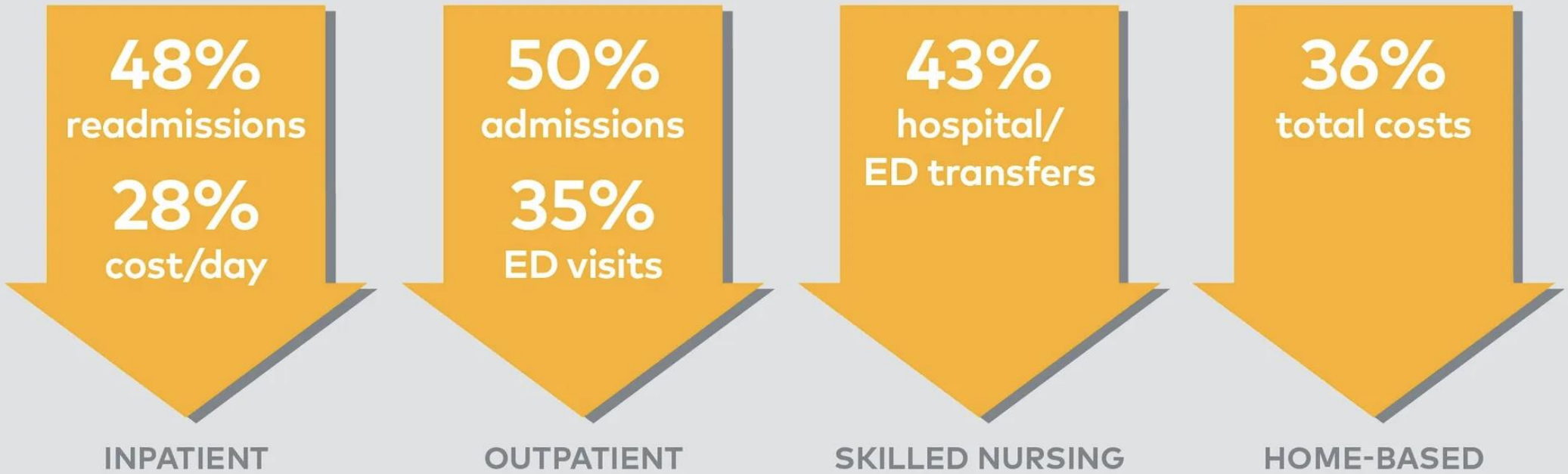
- Only a physician can refer a patient for palliative care.
- The primary physician is excluded once palliative care is accepted.
- Once on palliative care, curative treatment is no longer availab

Palliative Care Medical Definition

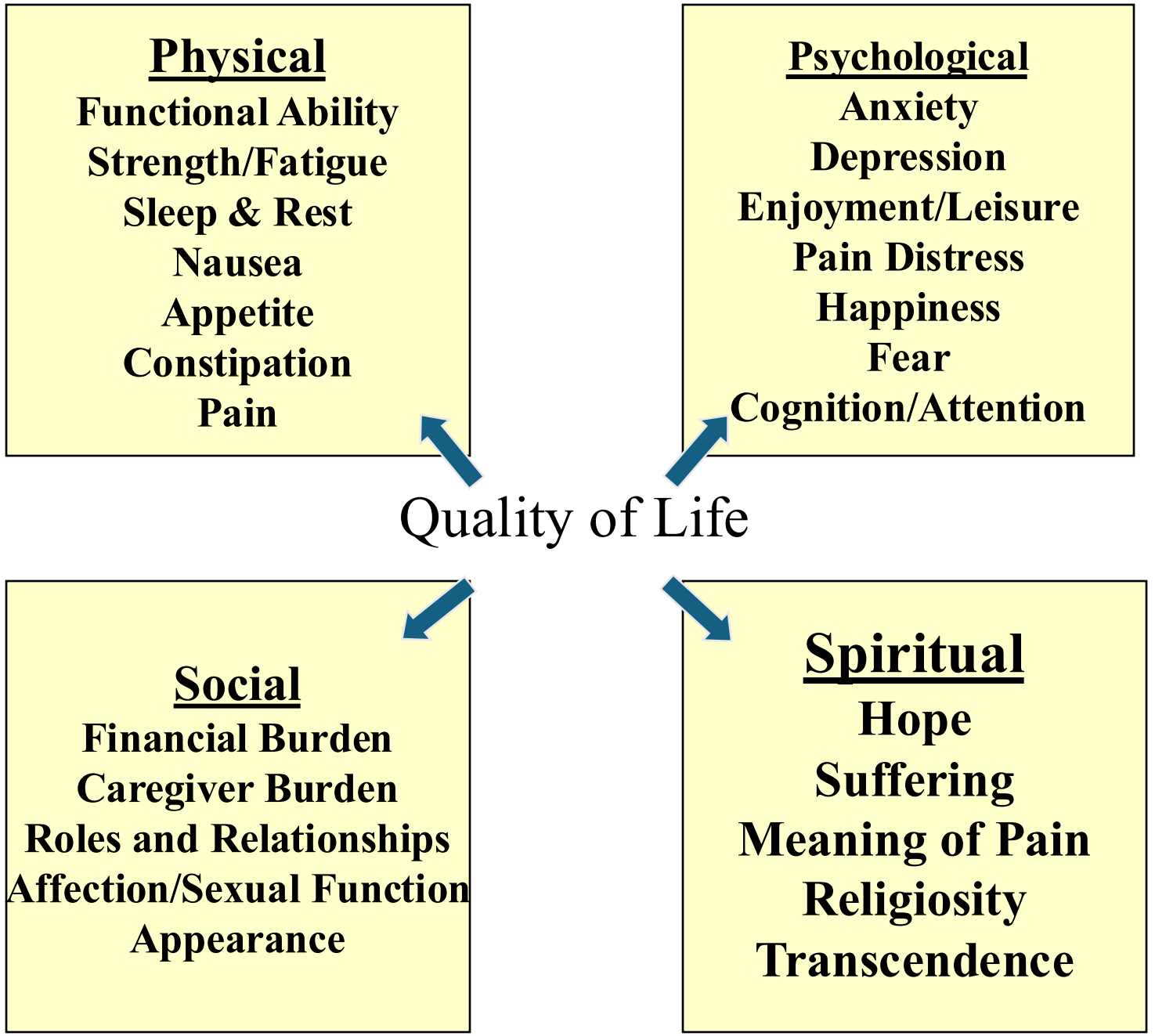
“Palliative care sees the person beyond the disease. It is a fundamental shift in health care delivery; it is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family.”

(Center to Advance Palliative Care website)

PALLIATIVE CARE REDUCES AVOIDABLE SPENDING AND UTILIZATION IN ALL SETTINGS



Source: Center to Advance Palliative Care


Physical
Functional Ability
Strength/Fatigue
Sleep & Rest
Nausea
Appetite
Constipation
Pain
Psychological
Anxiety
Depression
Enjoyment/Leisure
Pain Distress
Happiness
Fear
Cognition/Attention
Quality of Life
Social
Financial Burden
Caregiver Burden
Roles and Relationships
Affection/Sexual Function
Appearance
Spiritual
Hope
Suffering
Meaning of Pain
Religiosity
Transcendence

How does Palliative Work with LTCF Staff

- Person-Centered Approach
- Skillful Communication
- Addresses Complexity
- Documentation and Action

What Palliative Care Really Is!

- An extra layer of support- medical, social, spiritual
- Improves quality of life for people with serious illness
- Not based on prognosis
- Requires a specialized trained interdisciplinary team
- Assists in managing symptoms and distress
- At any age, at any stage of a serious illness
- Based on the needs of the patient
- Provided along with curative care

Pain and symptom management

Relief of psychological, emotional, and spiritual suffering

Communication about goal-setting and what to expect

Family caregiver support

Practical and social support

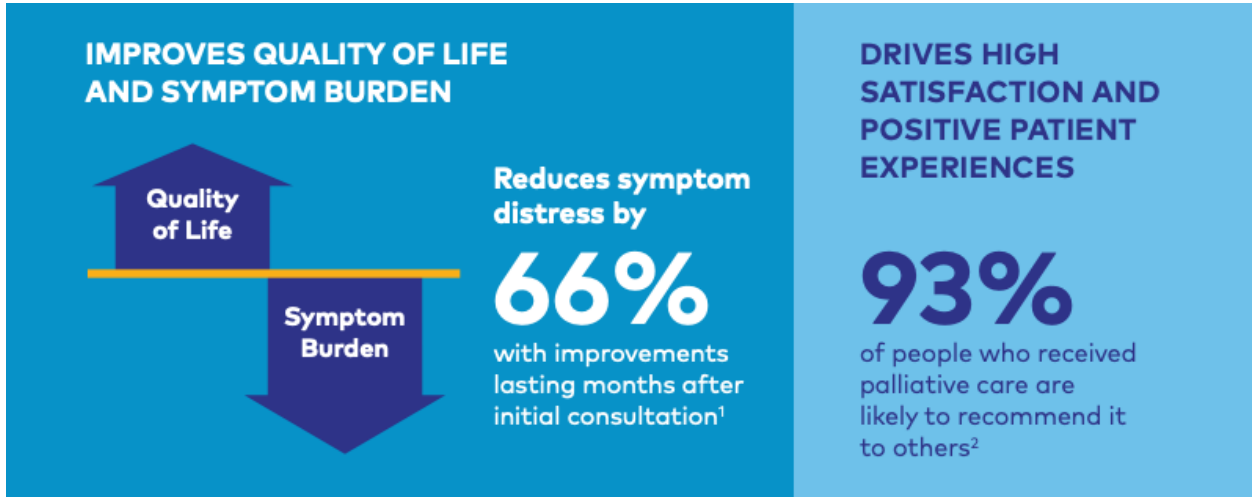
Palliative Care = Value

To the Resident & Family

- Focuses on patients' values, not disease specific
- Provides relief from the symptoms and stress of a serious illness.
- Improves quality of life for both the patient and the family.
- Gives patients options for pain & symptom management while still pursuing curative measures.

To the Healthcare System

- Value-based care
- Cost containment



(Palliative Care Ensures Value , CAPC flyer)

Why Is Palliative Care Needed?

- Advances in medical care allow people to live many years with serious and chronic illness.
- Our population is aging, especially in rural communities.
- Increasing cost of medical care has an impact on individuals, communities, society.
- A holistic approach is required to meet the complex needs of patients and families.
- Skills, processes, and system improvements improve health care.

How Palliative Care Supports Advance Care Planning

- **Holistic Support**
- **Facilitate Conversations**
- **Goal-Centered Care**
- **Ensuring Consistency**
- **Comprehensive Documentation**

Benefits of Integrating Palliative Care and ACP

- Improved Quality of Life
- Increased Patient and Family Satisfaction
- Better Outcomes
- Enhanced Communication
- Involves an interdisciplinary team
- Helps prevent unwanted care

Serious Illness

- A health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregiver.*
- - Irreversible, progressive.

(Kelley, AS, Bollens-Lund, E. Identifying the population with serious illness: the "denominator" challenge. Journal of Palliative Medicine. Volume: 21 Issue S2: March 1, 2018.)

Serious Illness in America: Impact on Aggressive Treatment

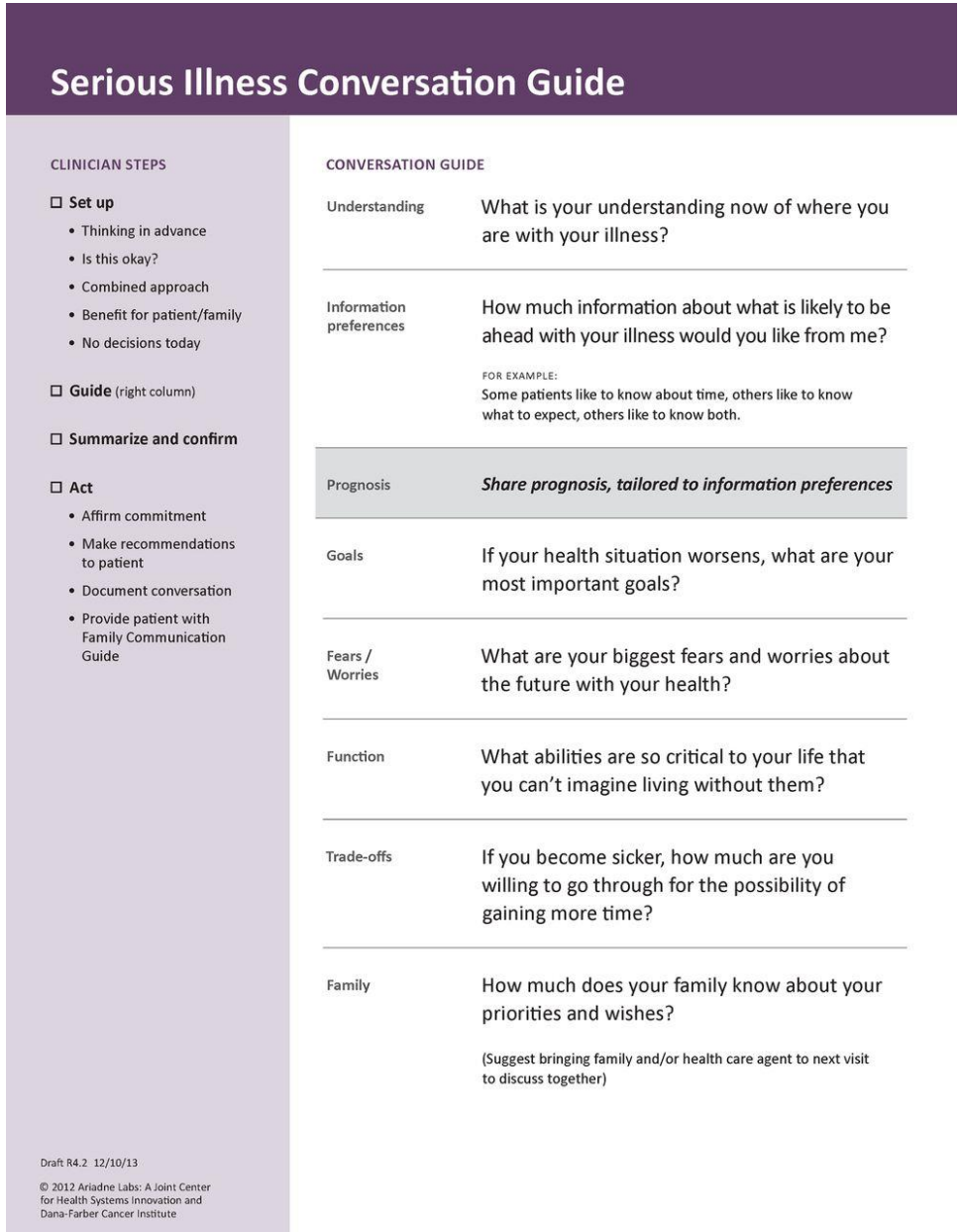
- Technology may prolong life (but not restore it)
- Poor understanding of prognosis
- Frailty, chronic illness
- Failure to treat pain and other symptoms
- Increased use of technology
- Exploding healthcare costs
- Lack of control over rising drug/device costs
- Not establishing “what matters” and what “matters most” to the individual

the **conversation** project

Institute *for* Healthcare Improvement

- **The Conversation Project®** is a public initiative to help individuals talking about advance care planning

Serious Illness Conversation Guide



Serious Illness Conversation Guide

CLINICIAN STEPS

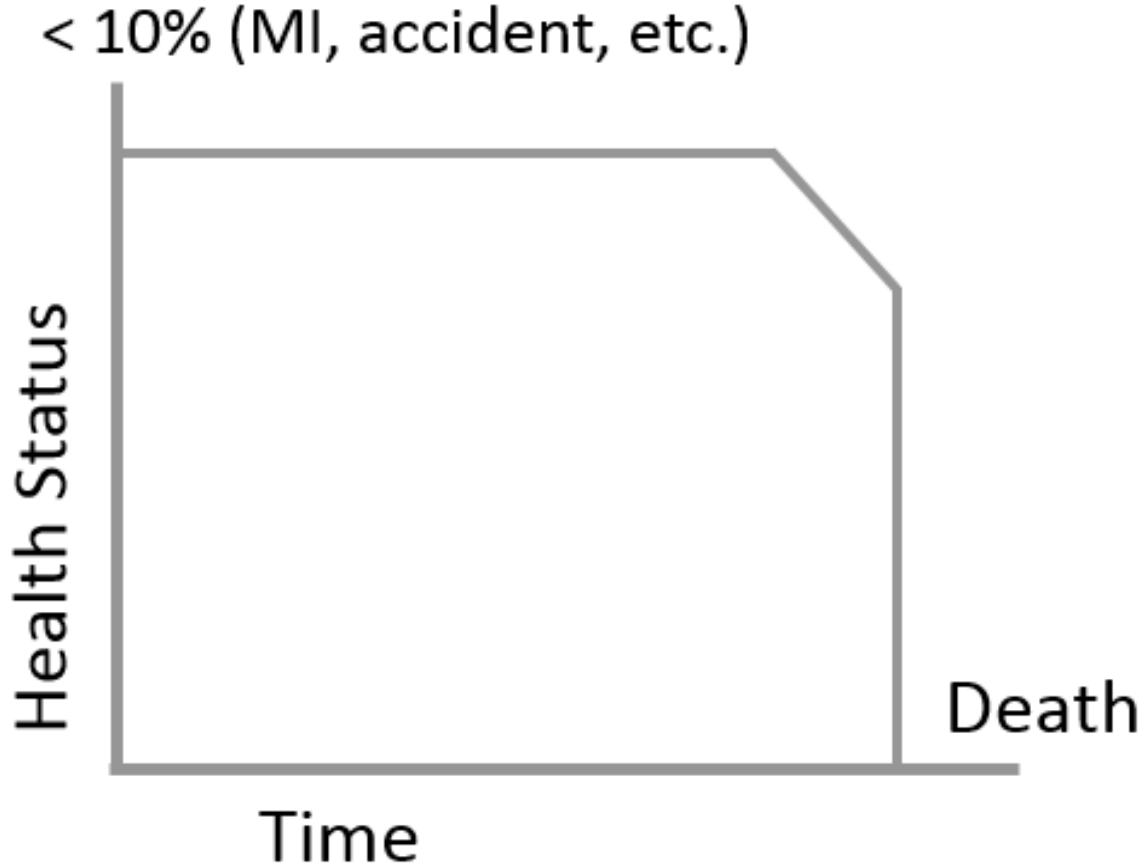
- ☐ **Set up**
  - Thinking in advance
  - Is this okay?
  - Combined approach
  - Benefit for patient/family
  - No decisions today
- ☐ **Guide** (right column)
- ☐ **Summarize and confirm**
- ☐ **Act**
  - Affirm commitment
  - Make recommendations to patient
  - Document conversation
  - Provide patient with Family Communication Guide

CONVERSATION GUIDE

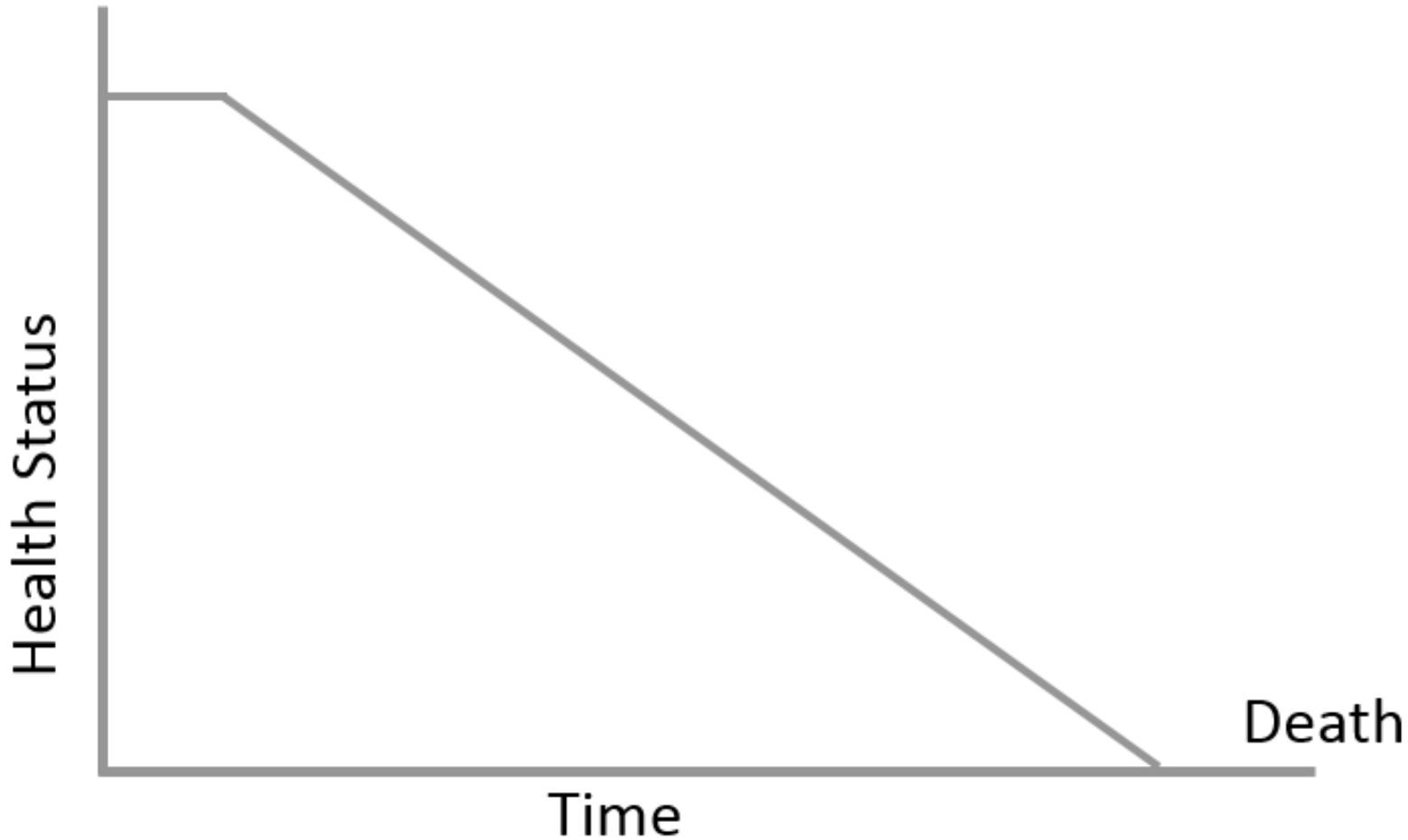
Understanding	What is your understanding now of where you are with your illness?
Information preferences	How much information about what is likely to be ahead with your illness would you like from me? FOR EXAMPLE: Some patients like to know about time, others like to know what to expect, others like to know both.
Prognosis	***Share prognosis, tailored to information preferences***
Goals	If your health situation worsens, what are your most important goals?
Fears / Worries	What are your biggest fears and worries about the future with your health?
Function	What abilities are so critical to your life that you can't imagine living without them?
Trade-offs	If you become sicker, how much are you willing to go through for the possibility of gaining more time?
Family	How much does your family know about your priorities and wishes? (Suggest bringing family and/or health care agent to next visit to discuss together)

Draft R4.2 12/10/13

Illness/Dying Trajectories Sudden Death, Unexpected Cause

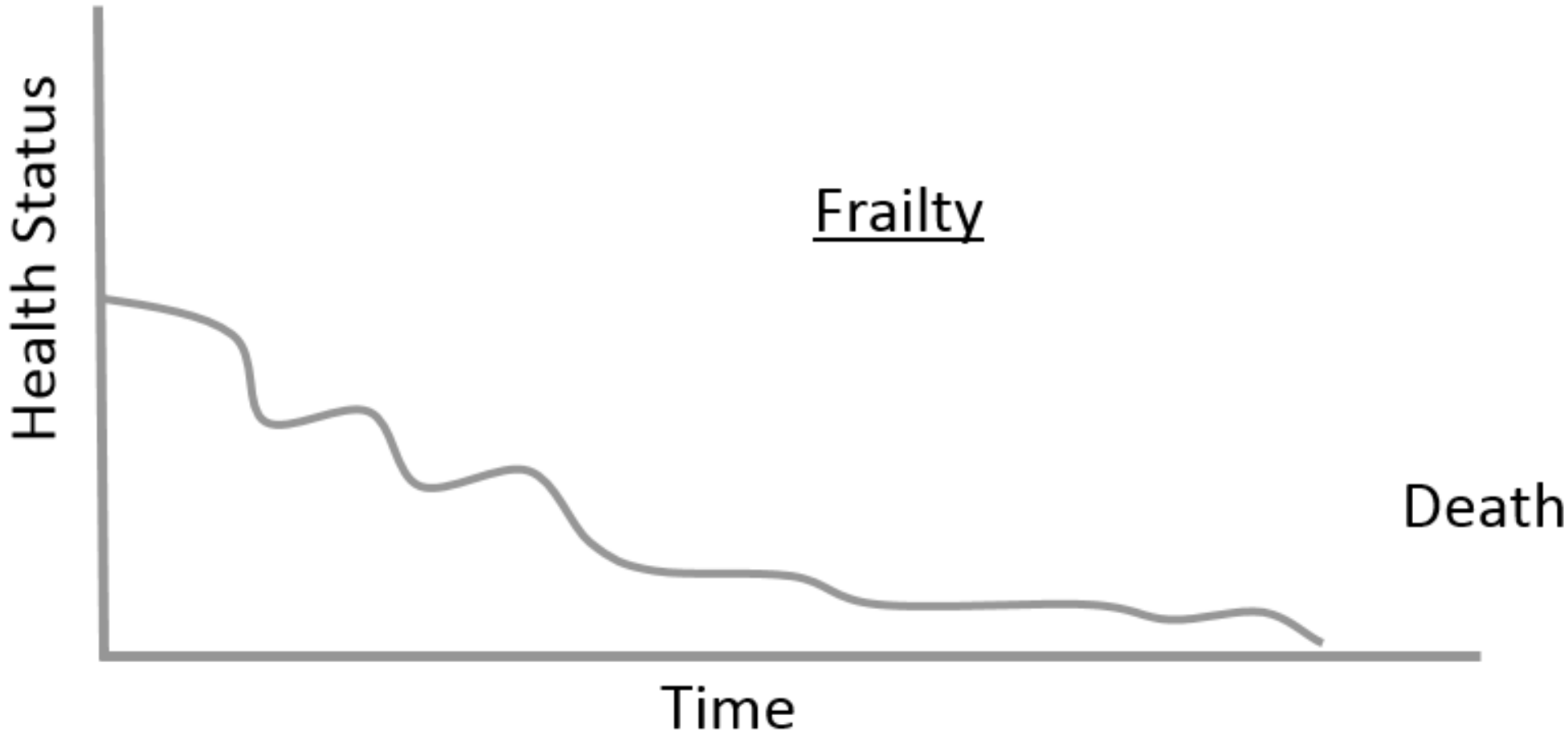


Illness/Dying Trajectories Steady Decline, Short Terminal Phase

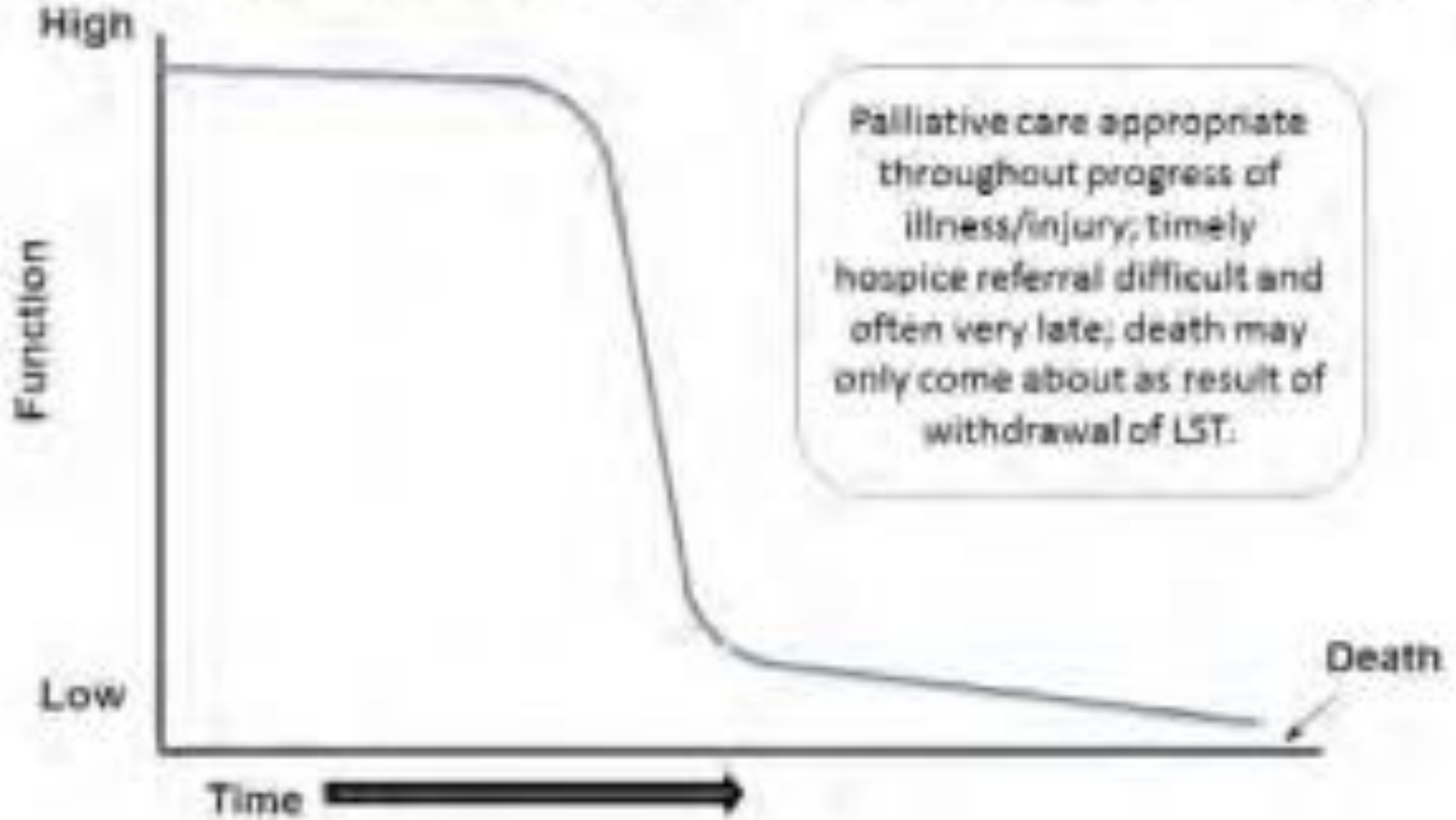


Illness/Dying Trajectories
Chronic Illness, Periodic Crises, Death

Illness/Dying Trajectories, Progressive Deterioration Expected Death



Catastrophic Event
(Stroke, TBI, Hip Fracture in Elderly)



“Comfort Care”

- Ambiguous
- Always provided for all levels of treatment
- NOT Equal to “All or nothing”
- Combination of treatment and palliation
- Essential part of medical **care** at the end of life
- Prevent or relieve suffering as much as possible
- Improves quality of life while respecting the dying person's wishes.

Comfort Measures Only

- Medication & treatments
- Any route
- Wound care
- Positioning
- Relief of pain and suffering (physical, psychological, social, spiritual)
- Allowing natural process of dying
- More attention on psychological and spiritual needs of the patient
- Support for both the dying patient and the patient's family.

Medical Definition of Hospice Care

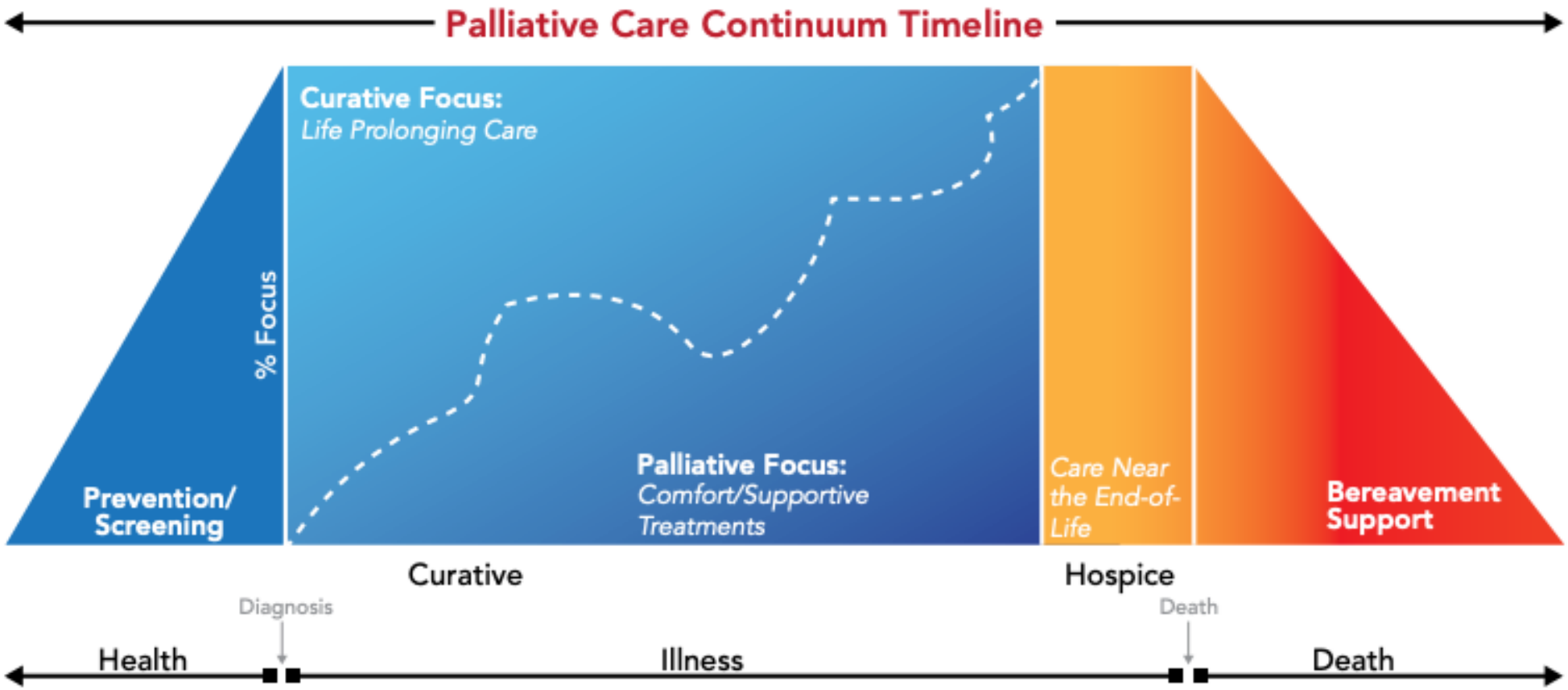
“Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure. The goal is to enable patients to be comfortable and free of pain, so that they live each day as fully as possible.”

(Davis, 2021)

Latin word "hospis," meaning host and guest.

Center *for* Rural Health
University of North Dakota
School of Medicine & Health Sciences

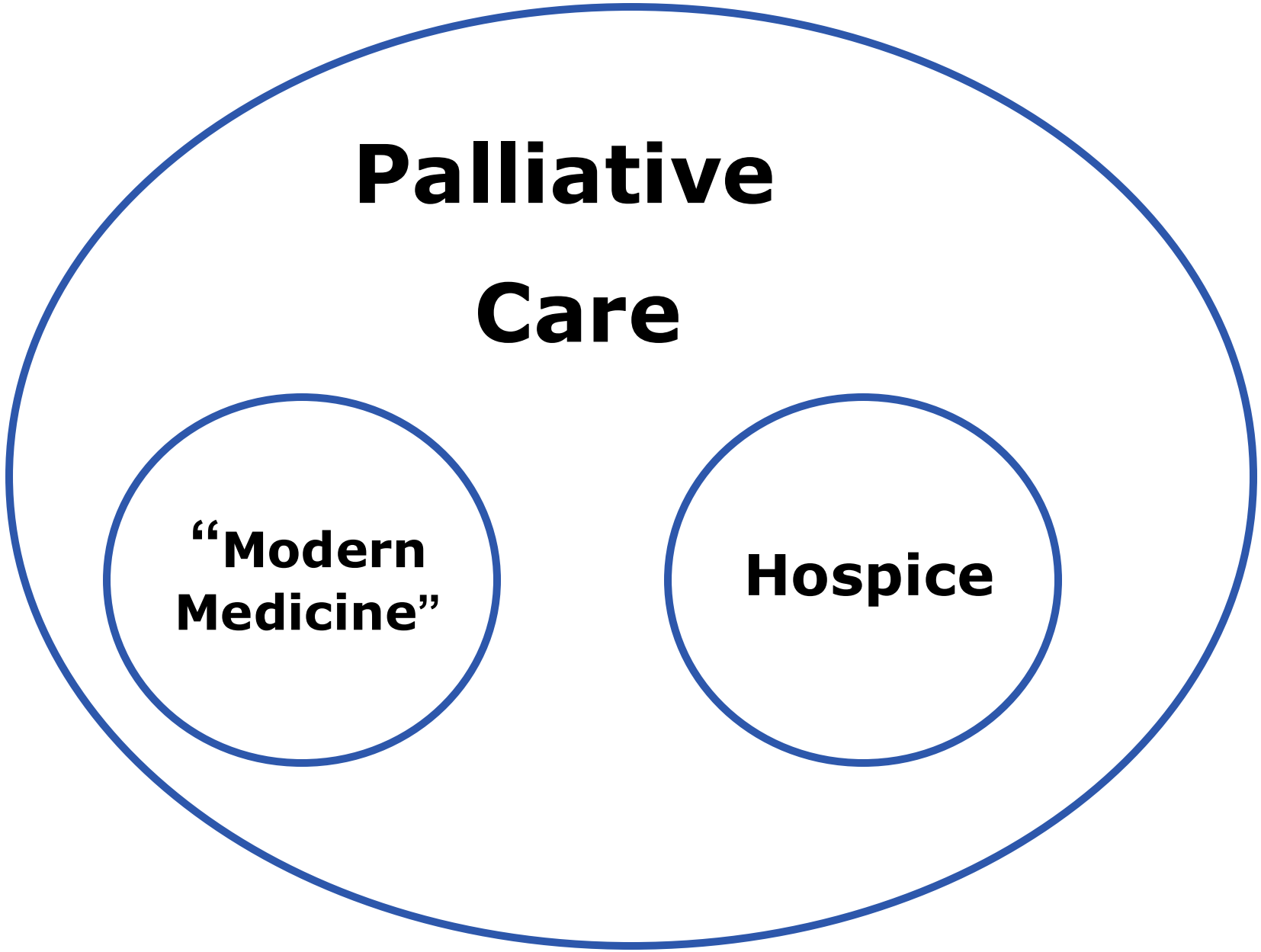
Quality Health Associates *of* North Dakota



Palliative Care or Hospice (ND Flyer)

Distinction Between Palliative Care & Hospice

	Palliative Care	Hospice Care
Who qualifies	Anyone, any age or stage, living with a serious illness	Those with a life expectancy of months, not years, with a terminal condition
When to start	From the time of diagnosis through treatment and living with a serious illness	Choice has been made to stop or go without curative treatments
Referral required?	No. Ask your healthcare team to add	Yes. From a physician. Requires an order
Additional Goals	Advance care planning, information about diagnosis & prognosis, navigating treatment options, referrals to community resources, continuity of care	Compassionate comfort care, preparing for the end of life


Palliative Care
“Modern Medicine”
Hospice

Key Takeaways- The Truths about ACP

- Advance Care Planning- Defined=For Everyone, any age, any condition
- Usually more than one ACP conversation is needed
- Acknowledge the continuum & and factors in the ACP process.
- We are all responsible for knowing ACP and having ACP conversations
- Advance Directives and POLST forms are the documents from ACP discussions

Key Takeaways- The Truths about Palliative Care

- Palliative Care is not hospice
- Serious Illness
- Extra Layer of Support
- Any age or diagnosis
- NOT based on prognosis
- Serious illness is more than diagnosis prognosis
- Interdisciplinary Team Approach (including LTC team)

Free ACP App and ACP Resources for Health Care Professionals

- Vital Talk Tips for Apple or Android(ongoing, Cambia)
- Fast Facts (ongoing, Palliative Care Network of Wisconsin aka, PCNOW)
- Serious Illness Conversation Guide (2023, Ariadne Labs Serious Illness Program)
- National POLST- Intended Population & Guidance for Health Care Professionals (2019, POLST)
- Conversation guides for advance care planning (2025,CAPC/Vital Talk)
- Coda for Professionals (2025,Coda Alliance)
- MLN Fact Sheet Advance Care Planning (March 2025,CMS-MLN909289)
- State specific Advance Directives/Health Care Directives
- State Specific Informed Health Care Consent Law-defining hierarchy of decision making if no healthcare POA

Internet ACP Information

- **Advance Care Planning: Advance Directives for Health Care (NIH)**
- **My Health Priorities** (Patient Priorities)
- Health Priorities Identification Quick Guide (Patient Priorities)
- Consumer's Toolkit for Health Care Advance Planning (American Bar Association)
- Five Wishes (Aging with Dignity)
- MyDirectives (ADVault Inc.)
- End-of-Life Decisions (Caring Info, National Alliance for Care at Home)
- Caring Conversations (2021, Center for Practical Bioethics)
- Advance Care Planning Conversation Guide (2014, Coalition for Compassionate Care of California)
- Getpalliativecare.org

ACP Worksheets/Workbooks

- Think About What Matters Most When Making Medical Decisions (NIH)
- Health Priorities Identification Quick Guide (Patient Priorities)
- Your Conversation Starter Guide (The Conversation Project)
- What Matters to Me Workbook (The Conversation Project)
- **Advance Care Planning: A Conversation Guide (NIH/NIOA)**
- **Toolkit for Advance Health Care Planning (ABA, 2020)**
- **Five Wishes (Aging With Dignity, n.d.)**
- PREPARE for Your Care Advance Directive
- State specific Advance Directives/Health Care Directives
- State Specific Informed Health Care Consent Law-defining hierarchy of decision making if no healthcare POA
- State specific POLST Portable Medical Orders

North Dakota Resources for Palliative Care

- North Dakota Palliative Care Taskforce web page
- Palliative Care or Hospice? Definition, Diagram, Distinction flyer
- North Dakota Rural Community-Based Palliative Care webpage
- Community-based Palliative Care Resources
- Honoring Choices® North Dakota website
- North Dakota POLST Program website
- Rural Hospice and Palliative Care website
- Rural Community-based Palliative Care Resource Center website

North Dakota Palliative Care Education

- Organizing Palliative Care for Rural Populations TeleECHO
- Previous Palliative Care Tele ECHO Clinics
- ND POLST Awareness, Education, and Implementation
- Advance Care Planning (ACP) Facilitator Training

References

- About Palliative Care (CAPC webpage)
- Achieving Value Through Palliative Care
- Davis, 2021. Medical Definition of Hospice care
- Demonstrating Value to Stakeholders (CAPC website)
- Kelley, AS, Bollens-Lund, E. Identifying the population with serious illness: the “denominator” challenge. Journal of Palliative Medicine. Volume: 21 Issue S2: March 1, 2018.
- Messaging Palliative Care (CAPC)
- National Consensus Project for Quality Palliative Care (NCP), https://www.nationalcoalitionhpc.org/ncp/

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- National Coalition for Hospice and Palliative Care's National Consensus Project Stakeholder Strategic Directions Summit , 2017
- Palliative Care Ensures Value (CAPC flyer)
- **Palliative Care for Clinicians | Consultations**
- Palliative Care or Hospice (ND Flyer)
- Palliative Care: YOU Are a BRIDGE (CAPC)
- Rosa WE, Ferrell BR, Mason DJ. Integration of Palliative Care Into All Serious Illness Care as A Human Right. JAMA Health Forum. 2021;2(4):e211099. doi:10.1001/jamahealthforum.2021.1099

For More Information

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