# Advance Care Planning in GP offices using virtual care

A. Patient selection

Criteria : > 70 yrs
Comorbidities including HT, DM, COPD, incurable Cancers, IHD, CHF, advance Neurological conditions, advanced Dementia.

B. Goals Of Care (GOC) discussion

Starting conversation with patients who fulfill criteria
_ Ask permission to have this conversation
- Start with getting the lay of the land:

- Surprise question to yourself – would you be surprised if this patient was no longer in the next 12 months

Great tips on how to navigate conversation- short

http://bit.ly/SeriousIllnessConversationGuide
http://bit.ly/SeattleVitalTalkCOVID19

Another Good pearls from Dr. Apostle

GOC in times of COVID – adapted from a post by Dr. Nicki Apostle

- Most people do not want to be kept alive if there is no hope for meaningful recovery.
- Value independence, cognitive awareness, and ability to communicate/interact with loved ones, some degree

of physical ability, and the alleviation and prevention of suffering.

- For those whom are frail and elderly living with multiple comorbidities critical care interventions have always threatened and gone against these values. Even before COVID-19, life support was associated with prolonged suffering and dying without extending quality of life in any meaningful way in this subset of the population.
- There is huge media attention being given to frail elders being “left to die” in the face of COVID-19. These specific patients are dying from COVID-19. The use of critical care resources would not change their outcome but would cause widespread individual and systemic harm.
- The best medical advice remains, and will always remain, that in these frail populations, with this catastrophic illness, life support should be avoided. This is not because they should be saved for younger, healthier populations with more “to contribute” but because we need to protect our frail elder population from interventions that themselves contribute to added harm and suffering without providing any meaningful benefit.

Palliative care communication pearls:

1. Be mindful to avoid careless language - use a careful, sensitive and culturally thoughtful approach.
2. Do not say; "there is nothing more we can do". This evokes neglect and abandonment and is simply inaccurate. There is always something we can do.

Focus on that. You may instead therefore say; “even though our efforts cannot be directed at curing, and progression to end of life is anticipated, there is still much we can do to care for you/your loved one.” (It is helpful to personalize here and list things that the patient may be experiencing and how you will address it – pain, dyspnea, agitation/delirium, family support etc.). I sometimes talk about aggressive symptom management (in the families that want “everything done”)

3. Do not say; “we are stopping/withdrawing care". We never stop "care". We refocus care by minimizing treatments that are only prolonging dying, adding to harm suffering, not providing any meaningful quality and inevitably not changing the course of illness. We then add treatments that optimize comfort, dignity and allow the least artificially prolonged course to natural end of life.
4. Do not give inappropriate options, confusing options or ask patients/family to come up with their own medical plan. Medical levels of care are far too complex for most patients/family to understand and giving options without direction often leads to choices that are inappropriate and/or nonsensical (for example wanting CPR but not intubation/defibrillation/ICU).

   For instance, DO NOT say, "do you want us to do everything", OR "if your heart stops do you want us to restart it". Phrase as, we should allow a natural death.
5. DO present the medical plan that you feel is best and articulate this with empathy and sensitivity. Most people do much better when given a direct medical plan and much less well when given options. This is an overwhelming and emotional time for patients and families. Do not expect them to have your degree of

understanding and realistic expectations to formulate appropriate complicated medical care plans. Tell them what is best using your expertise and compassion.

For instance, "Your loved one is very frail, even before this acute critical illness. I am gravely concerned that further life prolonging therapies will not only offer little to no chance of a meaningful recover, but that they pose a high risk of added suffering and prolonged dying. In addition, they will not change the inevitable course of this catastrophic illness. Furthermore, hospital based interventions would remove your loved one from their home environment and from their familiar care team. My recommendation, and what I strongly feel is the best medical plan, is to care for your loved one with aggressive symptom support here in their home."

If family is struggling they may say, "So we just let them die?" For which I offer the following "this illness will result in end of life with our without further medical interventions. Death is inevitable and it is sadly not a matter of us "letting" that happen or not. That is beyond our control. What we can control, however, is how end of life is experienced. It is my hopes we allow for the least artificially prolonged course to natural end of life with comfort and dignity as opposed to a medically prolonged dying process with high risk of added harm and suffering."

6. Do not say; "we are making you/your loved one palliative". We do not "make" people palliative and it is simply grammatically incorrect. We may transition goals to symptom/comfort support only but this is not synonymous with the term "palliative". Using it in this context propagates the misunderstanding and fears that

palliative = no active medical treatment/actively dying and creates further barriers to patients/families/clinicians wanting to see palliative providers.

7. Do not make assumptions about subjective concepts such as quality of life. Do try to establish what quality of life means for someone and use that to help guide an individualized care plan. I also find it helpful to say "what type of life prolonging therapies would you want for yourself if you were in your loved one's condition/shoes"? Most people are much better at understanding goals of care questions when it comes to how they want to be treated but feel "guilty" when those same opinions are used to guide goals of care of a loved one. Reassure them that focusing on comfort/quality is a reasonable and appropriate care plan; often the best care you can give someone in certain situations.

8. Do use purposeful hesitancy. It is ok to say "I don't know how to say this" or "I am really struggling to find the right words and I am sorry if I say something wrong". It is okay to take your time and hesitate in your language while you think carefully of the words you want to choose.

C. <u>Outcomes of this conversation – document</u>
After conversation and fill;

DNR
MOST
EDITH (notification of death form necessary in home- (your judgement) if Patient MOST 1 or 2

## D NEXT STEPS – REALLY IMPORTANT

Fill your portion DNR and MOST and EDITH (for MOST 1 or 2 patients)
Fax to Medical Records 604 – 984- 5718
Fax to palliative care services MOST 3 or below 604-984 3798

***We can provide pre-printed face sheets in the package saying Scan urgently into Cerner and fax numbers on the face sheet for Medical records and for North Shore palliative care 604- 984 -3798***

- From there on Dean and Mitch – Cerner and therefore the hospital will have up to date Advanced directive DNR status and hopefully MOST status on patients
- M1 and M2 patients will be entered into Plexia and followed up by community if needed (at least they will now be on the radar)
- **Supportive management of patients in community will mail /deliver the the DNR and EDITH forms to patients in community not a GP responsibility if the whole conversation has been virtual**
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- If GPs need support whether it is for medication guidance or anything palliative contact PCOC through LGH switchboard. 604 988 3131

- IF GP wants to direct dying at home then they contact PCOC who will arrange for Medkit to be delivered to the home. We now have 3 site pharmacies who are able to do that

- -PCOC can also arrange urgent nursing if needed and support GP to access that expeditiously

This is my working document with websites to help with starting conversation - Seattle website and Nicki Apostles pearls are worth reading. It really helps with focussing on getting pertinent information using right language and sensitively.

Hope this helps
Best
Anis