Normalizing Advance Care Directives

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Rural Lecture Series

Resources

- **Forms and Booklets:**
  - **Advance Care Planning Guide: Your Care, Your Choices**
  - **Advance Health Care Directive**
  - **Expected Death**

http://share.home.anthc.org/anmc/him/Health%20Record%20Approved%20Forms/Forms/AllItems.aspx?RootFolder=%2fanmc%2fhim%2fHealth%20Record%20Approved%20Forms%2fAdvance%20Care%20Planning%20Documents&FolderCTID=0x012000A623B58033F32E4AA0F4D100A25CD981

- **SCF Palliative Care Action Plan for Covid 19**

http://sharepoint/primarycare/Shared%20Documents/Project%20and%20Process%20Documentation/Palliative%20Care%20and%20Advanced%20Directives/COVID-19/Palliative%20Care%20COVID%20Action%20Plan%20and%20Tip%20Sheet.pdf

GOAL

75% of Adult panel with Advance Care Directive

OBJECTIVES

1. **Appreciate that our current situation provides an opportunity**
2. **Understand the Advance Care Directive**
3. **Leverage CERNER**

Opportunity For Change

- For us: time to spend with CO checking on their welfare and educating
- For our customer: aware of need for change, will support change, want knowledge of how to do it - *does not just apply to social distancing*
- Corporate: ability to see CO 'virtually' has expanded tele-med, telephone, tele-video virtual patient room

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#DigitalTransformation in a nutshell:

Who led the digital transformation of your company?

A) CEO

B) CTO

C) COVID-19

The Advance Care Directive

- Provider level of comfort with this subject is very important
  - Do you have an Advance Care Directive?
  - If not, why not?

- Focus is on why an Advance Care Directive is important
    - It is about having a voice
    - Not about death but about being alive and not having a voice
    - Common what if scenarios
    - Common relationship issues
    - The CERNER dilemma

Leveraging CERNER

- Assure it is a billable encounter
- ICD10: Z71.89 advance care planning and COVID advice
- Use visit as chart review
- Integrate the visit
- Create templates
- Explore auto text (# %)
- CERNER points

Documentation

This Patient gave consent for me to conduct this visit via telephone.
Provider Location: McGrath
Patient Location: Home, Upper Kuskokwim
Names/roles of other participants: NA
Reason for Visit: COVID Check in and Advance Directive Z71.89

Additional: Tobacco F17.200, PrimeMD Z13.31, polypharm risk Z91.89
DOS: 05/01/2020
Start time: 1100
Stop time: 1145

- Above booked as a telephone encounter
  - If televideo or virtual patient room the documentation needs to reflect this

Documentation: Covid Check

- CO is feeling well. CO has no cough, fever, body aches, shortness of breath, nausea, vomiting, anorexia, diarrhea, change in taste or smell, or new onset rash/redness. No recent travel, no contact with known COVID.
- CO **does not have enough food and groceries**. She is on a very limited income, there is no store where she lives, she does not have internet, she does not have long distance, and she only has a debit card and food stamps.
- CO is aware of need for social distancing and mask use; CO is a widow and lives alone and has been **feeling 'kind of down'** during the 'hunker down' mandate. When asked what makes her sad she replies 'no hugs'.

Documentation: Covid Check (continued)

- **SBIRT and Prime MD** performed
- Enrolled in **smoking cessation** program and is not doing well. Smoking 5-10 cigarettes daily. Has lozenges, patches, gum, welbutrin. Patches make her break out, she does not like the lozenges or gum and does not feel that she wants to quit at this time.

Documentation: ACD

- Anyone age 18 and older may fill out an Advance Health Care Directive also known as a living will
  This advance directive follows Alaska law in respecting a patient's right to make decisions about his/her health care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives
  Your Health Care Agent must be able to speak on your behalf. Your Health Care Agent does not have to be a family member. They can be a close friend or neighbor. The person (or people) you choose as your Health Care Agent should be someone:

  - Who knows you well and who can understand and follow your medical wishes: re-visit
  - Who you trust to speak as your voice
  - Who can be easily reached by telephone: re-visit
  - Your Health Care Agent should be able to answer 'yes' to these questions:
    - Is he or she willing to be my health care agent?
    - Does he or she fully understand my medical wishes?
    - Can he or she make health care decisions for me in stressful situations, even if my medical wishes may be different than his or hers? re-visit
    - Consider choosing a different person as your Health Care Agent if they answered 'no' to any of these questions or if they seem uncomfortable talking about your health care decisions.

Documentation: ACD (continued)

- Informed that Advanced Directive:
  - may be notarized or witnessed
    - a copy of your advance directives will be maintained in your health record.
    - should be reviewed annually to make sure it still represents your wishes.
    - if you need/desire to make changes, you may make a new Advance Health Care Directive at any time
    - Original will be mailed back to you for your records

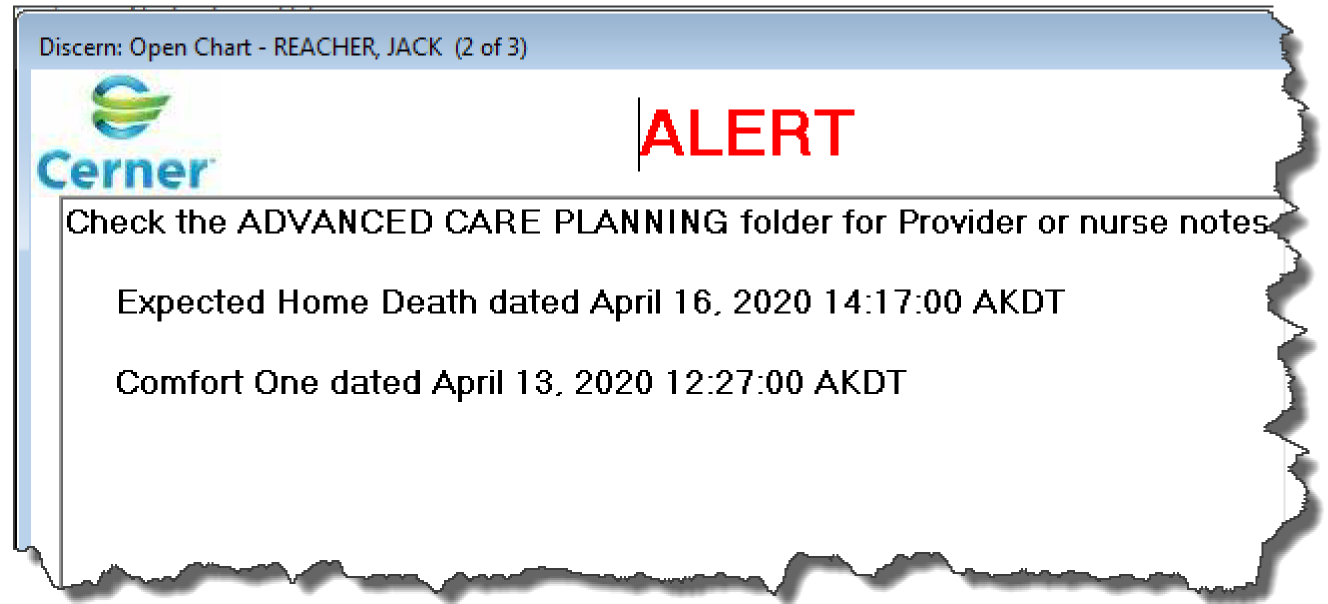
Documentation: Assessment and Plan

- Assessment/Plan:
  - Will continue to discuss Advance Directive 5/4/2020 at 11AM. CO is very willing to discuss but wants to think about and further discuss who would be her health care surrogate as her son disagrees with her wishes to be cremated and her daughter suffers from addiction, neither has a phone.
  - Reconciled and renewed meds, messaged pharmacy
  - Tobacco cessation specialist notified to recontact in 1 month
  - Prime MD positive for mild depression attributable to situation: contact by phone bi-weekly to assess and maintain contact
  - SBIRT negative
  - Clinic staff to check in periodically to assess health, welfare, and any concerns
  - At next call: facilitate plan for grocery delivery, continue discussion of an advance directive, counsel for nutrition and exercise, arrange for Wellness Care Plan update at subsequent visit

CO verbalized understanding of plan. Will contact week of 5/4/2020.

CERNER Points

- Really nice alert but: Only pops the first time you open the chart that day
- How quickly and easily can you access the actual ACD?
- How fast can you access the surrogate(s) name and phone number(s)?
- If no ACD: how do you access emergency contact?
- Emergency contact/HCS often not the same
- Gray menu: patient info: no emergency contact but does have ACD box which is apparently not linked
- DB needs to be normalized



Remember: Rural clinics have few providers and rarely have ancillary staff and almost never between 5PM and 8AM