Advance Care Planning: Starting the Conversation
Agenda

A PDF of this presentation and a link to the recording will be emailed to you in about 5 working days.

• Advance care planning
  • Ariadne Labs framework & guide
  • Discussion structure & examples
  • Advance health care directives
  • Q&A

• Home-Based Palliative Care (HBPC) Program
  • Overview
  • HBPC Program referral & enrollment
  • Q&A
Meet the Home-Based Palliative Care team

Kimberly Bower, MD, FAAHPM, HMDC Medical Director

Jenelle Hallock, MHA Senior Manager

Kim Beverly, MSW, MSG Clinical Program Manager

LaFiaun Coats, LVN Clinical Program Manager

Gabriele Pierce, RN Clinical Program Manager

Anna Berens Program Manager

Kristen Vallone Program Manager

Beth Doyle Program Manager
Advance care planning
What is advance care planning?

- An ongoing conversation that evolves as the patient’s condition and circumstances change
- Who is the patient?
  - What gives joy?
  - What is most important?
  - What are the underlying values?
- How various medical treatments might support or interfere with the patient’s values and priorities
Advance care planning for providers & patients

- Ariadne Labs framework / Serious Illness Conversation Guide and What Matters to Me workbook
Advance care planning for patients

- Ariadne Labs framework / What Matters to Me Workbook
- Palliative care page on Blue Shield of California member website
  - Go to: blueshieldca.com > Conditions and care programs > Palliative care
What Matters to Me patient workbook

My Health

1. What is your understanding of your current health situation?

2. How much information about what might be ahead with your illness would you like from your healthcare team?

About Me

3. MY GOOD DAYS • What does a good day look like for you? Here are some things I like to do on a good day:

   EXAMPLES:
   - Get up and dressed
   - Play with my cat
   - Make a phone call
   - Watch TV
   - Have coffee with a friend

4. MY HARD DAYS • What does a hard day look like for you? These are the toughest things for me to deal with on a hard day:

   EXAMPLES:
   - Can't get out of bed
   - In a lot of discomfort
   - No appetite
   - Don't feel like talking to anyone

5. MY GOALS • What are your most important goals if your health situation worsens? These are some things I would like to be able to do in the future:

   EXAMPLES:
   - Take my dog for a walk
   - Attend my child's wedding
   - Feel well enough to go to church
   - Talk to my grandchildren when they come to visit

My Care

1. As a patient, I'd like to know...

   - Only the basics about my condition and my treatment
   - All the details about my condition and my treatment

2. When there is a medical decision to be made, I would like...

   - My health care team to make all the decisions
   - To have a say in decisions whenever possible

3. What are your concerns about medical treatments?

   - I worry that I won't get enough care
   - I worry that I'll get too much care

4. How much medical treatment are you willing to go through for the possibility of gaining more time?

   - Nothing: I don't want any more medical treatments
   - Everything: I want to try any medical treatments possible

5. If your health situation worsens, where do you want to be?

   - I strongly prefer to be in a healthcare facility
   - I strongly prefer to be at home, if possible

6. When it comes to sharing information about my illness with others...

   - I don't want those close to me to know all the details
   - I do want those close to me to know all the details
What Matters to Me patient workbook (continued)

1. **MY FEARS AND WORRIES** - What are your biggest fears and worries about the future with your health?
   These are the main things I worry about:

   **EXAMPLES**
   I don't want to be in pain • I'm worried that I won't be able to get the care I want • I don't want to feel stuck someplace where no one will visit me • I worry about the cost of my care • What if I need more care than my caregivers can provide?

2. **MY STRENGTHS** - As you think about the future with your illness, what gives you strength?
   These are my main sources of strength in difficult times:

   **EXAMPLES**
   My friends • My family • My faith • My garden • Myself (“I just do it”)

3. **MY ABILITIES** - What abilities are so critical to your life that you can’t imagine living without them?
   I want to keep going as long as I can...

   **EXAMPLES**
   As long as I can at least sit up on the bed and occasionally talk to my grandchildren • As long as I can eat ice cream and watch the football game on TV • As long as I can recognize my loved ones • As long as my heart is beating, even though I’m not conscious

If you become sicker, which matters more to you: the possibility of a longer life, or the possibility of a better quality of life? Please explain.

4. **MY WISHES AND PREFERENCES** - What wishes and preferences do you have for your care?
   If my health situation worsens, here’s what I want to make sure DOES happen:

   **EXAMPLES**
   I want to stay as independent as possible • I want to get back home • I want my doctors to do absolutely everything they can to keep me alive • I want everybody to respect my wishes if I say I want to switch to comfort care only

   And here’s what I want to make sure DOES NOT happen:

   **EXAMPLES**
   I don’t want to become a burden on my family • I don’t want to be alone • I don’t want to end up in the ICU on a lot of machines • I don’t want to be in pain

   Is there anything else you want to make sure your family, friends, and health care team know about you and your wishes and preferences for care if you get sicker?

5. **MY QUESTIONS** - What questions do you want to ask your health care team?

   **EXAMPLES**
   How will you work with me over the coming months? • What treatment options are available for me at this point — and what are the chances they’ll work? • What can I expect if I decide I don’t want more curative treatment? • If I get sicker, what can you do to help me stay comfortable? • What are the best-case and worst-case scenarios?
What Matters to Me patient workbook (continued)

My People

1. Are there key people who will be involved in your care (family members, friends, faith leaders, others)? For each person you list, be sure to include their phone number and relationship to you.

2. How much do they know about your wishes and preferences? What role do you want them to have in decision making? When might you be able to talk to them about your wishes?

3. Which person would you want to make medical decisions on your behalf if you’re not able to? This person is often called your health care proxy, agent, or surrogate. See the Guide to Choosing a Health Care Proxy for help.

   Name, phone number, relationship to me
   I have talked with this person about what matters most to me. □ Yes □ No
   I have filled out an official form naming this person as my health care proxy. □ Yes □ No
   I have checked to make sure my health care team has a copy of the official proxy form. □ Yes □ No

My Health Care Team

Who are the key clinicians involved in your care?

1. My primary care provider
   Name
   Phone number

2. My social worker
   Name
   Phone number

3. My main specialist
   Name
   Phone number

4. Other
   Name
   Phone number

Ariadne Labs ariadnelabs.org - The Conversation Project theconversationproject.org
Advance care planning conversation steps

1. Set up the conversation
2. Assess understanding and preferences
3. Share prognosis
4. Respond to emotion
5. Explore key topics
6. Close the conversation

Advance Care Planning Conversation codes:
- 99497: First 30 minutes
- 99498: Additional 30 minutes
1. **Set up the conversation**

- Prepare the setting
  - Quiet space
  - Enough time
  - Adequate seating
  - Tissues
  - Appropriate medical team members

- Introduce purpose
- Prepare for future decisions

- Ask permission

  “I’d like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want. **Is that okay?**”

- Ensure the right people are present

  “Is there anyone you would like to have with you while we have this discussion?”
2. Assess understanding and preferences

• Assess patient’s understanding

“What is your understanding now of where you are with your illness?”

• Assess decision making style

“How much information about what is likely to be ahead with your illness would you like from me?”

• Ask permission

“I’d like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want. Is that okay?”
3. Share prognosis

• Share prognosis

• Frame as a “wish...worry,” hope...worry” statement

• Allow silence, explore emotion

“I want to share with you my understanding of where things are with your illness...”

• *Uncertain*: “It can be difficult to predict what will happen with your illness. I hope you will continue to live well for a long time but I’m worried that you could get sick quickly, and I think it is important to prepare for that possibility.”

OR

• *Time*: “I wish we were not in this situation, but I am worried that time may be as short as ____ (express as a range, e.g. days-to-weeks, weeks-to-months, months-to-a-year).”

OR

• *Function*: “I hope this is not the case, but I’m worried that this may be as strong as you will feel, and things are likely to get more difficult.”
Respond to emotion

• Be quiet and allow the patient to process the information you have provided.

• Observe for emotion
  “It looks like this information is really upsetting to you. Tell me about how you are feeling.”

• Ask about emotion
  “Is this the information you were expecting?”
  “Some people feel scared or anxious or angry when they receive information like this. Are you having any of these feelings?”
5. Explore key topics

- **Goals**
  “What are your most important **goals** if your health situation worsens?”

- **Fears and worries**
  “What are your biggest **fears and worries** about the future with your health?”

- **Sources of strength**
  “What gives you **strength** as you think about the future with your illness?”

- **Critical abilities**
  “What **abilities** are so critical to your life that you can’t imagine living without them?”

- **Tradeoffs**
  “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?”
6. Close the conversation

• Summarize/make a recommendation

“I’ve heard you say that ___ is very important to you. Keeping that in mind, and what we know about your illness, I recommend that we ___. This will help us ensure that your treatment plans reflect what’s important to you.”

• Check in with patient

“How does this plan seem to you?”

• Affirm commitment

“I will do everything I can to help you through this.”
## Advance Healthcare Directive Form

### Part 1: Power of Attorney for Health Care

#### Designation of Agent

I designate the following individual as my agent to make health care decisions for me:

<table>
<thead>
<tr>
<th>(name of individual you choose as agent)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(address)</td>
<td></td>
</tr>
<tr>
<td>(city)</td>
<td>(state)</td>
</tr>
<tr>
<td>(ZIP Code)</td>
<td></td>
</tr>
</tbody>
</table>

#### Home Phone

(Optional) If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

<table>
<thead>
<tr>
<th>(name of individual you choose as first alternate agent)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(address)</td>
<td></td>
</tr>
<tr>
<td>(city)</td>
<td>(state)</td>
</tr>
<tr>
<td>(ZIP Code)</td>
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</tr>
</tbody>
</table>

#### Work Phone

(Optional) If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

<table>
<thead>
<tr>
<th>(name of individual you choose as second alternate agent)</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>(address)</td>
<td></td>
</tr>
<tr>
<td>(city)</td>
<td>(state)</td>
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<tr>
<td>(ZIP Code)</td>
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#### Agent’s Authority

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

#### When Agent’s Authority Becomes Effective

My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box, my agent’s authority to make health care decisions for me takes effect immediately.

### Physician Orders for Life-Sustaining Treatment (POLST)

- **Cardiopulmonary Resuscitation (CPR):** If patient has no pulse and is not breathing, patient is not in cardiopulmonary arrest, follow orders in Sections A and B.
  - **Do Not Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
  - **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
  - **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

- **Medical Interventions:** If patient is found with a pulse and/or is breathing.
  - Full Treatment – Primary goal: prolonging life by all medically effective means.
  - Selective Treatment – Goal: treating medical conditions while avoiding burdensome measures.
  - Comfort-Focused Treatment – Primary goal: maximizing comfort.

- **Artificially Administered Nutrition:** Offer food by mouth if feasible and desired.

- **Information and Signatures:**
  - Signature of Physician/Nurse Practitioner/Physician Assistant
  - Patient’s POA Signature (required)

### New York Advanced Care Directive Form

- **Advance Directive for Health Care:**
  - **Advance Directive for Health Care:**
    - Patient Name: [Name]
    - Name: [Name]
    - Date: [Date]
  - **No Advanced Directive:**
    - Patient Name: [Name]
    - Name: [Name]
    - Date: [Date]

- **Signature of Patient’s Legally Recognized Decisior:**
  - Patient Signature: [Signature]
  - Date: [Date]

- **Signature of Patient or Legally Recognized Decisior:**
  - Patient Signature: [Signature]
  - Date: [Date]

- **Signature of Patient or Legally Recognized Decisior:**
  - Patient Signature: [Signature]
  - Date: [Date]
Advance health care directive options

• Advance health care directives:
  • [California advance health care directive](#)
  • [Office of the Attorney General's website](#)

Five Wishes

- Easy-to-use legal advance directive for adults available in 30 languages.
- Speaks to medical, personal, emotional and spiritual needs.
- Helps guide and structure discussions with patient, family and physician(s).
- Meets legal requirements in 46 states but is used widely in all 50.

Voicing My Choices

- Empowers young people living with a serious illness to communicate to family, friends and caregivers how they want to be comforted, supported, treated and remembered.
- Developed specifically for young adults with feedback and guidance from young people living with a serious illness.
- Not legally binding.
Communicate with key clinicians

- It is important to communicate goals of care and/or advance care planning documents with the patient's primary care provider and/or specialists.
- Documentation in the electronic medical record is also needed.
HBPC Program overview
Home-Based Palliative Care (HBPC) Program overview

• Palliative care is a **standard medical service** offered to all Blue Shield of California members except
  • Medicare supplemental insurance (Medigap)
  • PPO Federal Employee Program (FEP)
  • Deferral Accommodation Plan (DAP)
  • Shared Advantage (where Blue Shield only provides the network)
  • Duals when Medicare is not with Blue Shield

• Members in the HBPC Program are **not charged copays or co-insurance** for services provided as part of the program.

• HBPC is provided by an interdisciplinary team of doctors, nurses, social workers and chaplains working with the patient’s other doctors to provide an extra layer of support.

• **If the patient continues to meet eligibility and there is a medical need,** there is no time limit on HBPC program enrollment.
# HBPC Program patient eligibility requirements

**General guidelines**

- Have an advanced illness
- Use hospital and/or ER to manage illness
- Willing to attempt home- and office-based management, when appropriate
- Not eligible for or declined hospice care
- Death within a year would not be unexpected
- Willing to participate in advance care planning discussions

**Diagnosis categories**

Include but not limited to:

- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Advanced cancer
- Liver disease
- Cerebral vascular accident/stroke
- Chronic kidney disease or end state renal disease
- Severe dementia or Alzheimer’s disease
- Other

- For Medi-Cal members: CHF, COPD, advanced cancer, liver disease
Blue Shield’s HBPC Program services*

24/7 access to help and support

Help with pain and other symptoms

Help with treatment decisions

Help with coordinated medical care

Support for family

Referrals to Blue Shield and community resources

Provided in settings throughout California, wherever the member needs or wants:
- At home (in 40 counties)
- Via phone or video in rural areas (in 18 counties)
- In skilled nursing facilities (SNF)

* For a program overview, see Palliative Care located on Blue Shield Provider Connection. There is also a Palliative care page on the Blue Shield of California member website.
Offering palliative care

1. Set the stage
   - Sufficient time
   - Interpretation
   - Support person

2. Listen to the member
   - What are the member’s challenges
   - What problem(s) are they most motivated to solve

3. Provide information
   - Explain how an **extra layer of support** can help address the member’s issue
   - Describe the services
     - “These services are provided by palliative care agencies. Are you familiar with palliative care?”
     - “Do you have any past experiences with palliative care?”

4. Respond to emotion
   - Does hearing about palliative care make you feel worried, relieved, etc.?”

5. Make a plan
HBPC Program provider listing

Find a palliative care provider

- Alameda County
- Alpine County
- Amador County
- Butte County
- Calaveras County
- Colusa County
- Contra Costa County
- Del Norte County
- El Dorado County
- Fresno County
- Glenn County
- Humboldt County
- Imperial County
- Inyo County
- Kern County
- Kings County
- Lake County
- Los Angeles County
- Madera County
- Marin County
- Mariposa County
- Mendocino County
- Merced County
- Modoc County
- Mono County
- Monterey County
- Nez Perce County

HBPC Program provider listing by county located on Provider Connection – no login required.

www.blueshieldca.com/palliativecare
Referral process

1. **Identify members**
   - Referring source:
     - Identifies potentially eligible members using Eligibility Screening Tool as guide

2. **Screening tool**
   - Referring source:
     - Completes Eligibility Screening Tool
     - Attaches clinicals
     - Emails completed screening tool and clinicals to Blue Shield HBPC Program team

3. **Verification**
   - HBPC team:
     - Verifies eligibility
     - Reviews notes
     - Sends referral to a contracted HBPC provider
       - HBPC team contacts referral source if member is not eligible

4. **HBPC provider**
   - HBPC provider:
     - Outreaches to member
     - Notifies Blue Shield and the referral source of outreach outcome
Eligibility Screening Tool

Palliative care services screening criteria for program participation

<table>
<thead>
<tr>
<th>Member Information</th>
<th>Referring party Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member name</td>
<td>Provider name</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Organization name</td>
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<tr>
<td>Evaluation date</td>
<td>Address</td>
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<td>City</td>
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<td>Phone number</td>
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For a plan member to be considered for participation in the Home-Based Palliative Care Program, the plan member must meet the following palliative care eligibility screening requirements.

**Section 1:** Eligibility criteria for all members

1. **General eligibility criteria**
   - The member must meet all of the general eligibility criteria.
   - The member is under the age of 21.
   - The family and/or legal guardian agrees to the provision of palliative care services.

2. **Disease-specific eligibility criteria**
   - Congestive heart failure (CHF): Must meet (a) and (b) below:
     - The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned OR meets criteria for the New York Heart Association's (NYHA) CHF classification II or higher.
   - Chronic obstructive pulmonary disease (COPD): Must meet (a) or (b) below:
     - The member has a forced expiratory volume (FEV) of 1 less than 31% of predicted AND a 24-hour oxygen requirement of less than 3 liters per minute.
   - Advanced cancer: Must meet (a) (AND (b) and (c) below):
     - The member has a Karnofsky Performance Scale score less than 70% OR has a performance of two or more days of standard of care therapy.

**Section 2:** Pediatric palliative care eligibility criteria

1. **General eligibility criteria**
   - The member must meet all of the general eligibility criteria.
   - The member is under the age of 21.
   - The family and/or legal guardian agrees to the provision of pediatric palliative care services.

2. **Disease-specific eligibility criteria**
   - Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy).
   - Progressive conditions for which treatment is exclusively palliative (e.g., progressive muscular atrophy).
   - Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

**Servicing provider**

- Indicate program status:
  - Member is enrolled in the program. (Enter enrollment date:)
  - Member did not agree to enroll in the program.
  - Member did not qualify for enrollment in the program.
  - Member enrolled in hospice.

**ACP/Specialist**

- I am referring the member to Blue Shield of California for a full Palliative Care Service Evaluation.
Referrals?
Complete the Eligibility Screening Tool and email or fax to the Blue Shield Home-Based Palliative Care Team:

- Email: bscpalliativecare@blueshieldca.com
- Fax: (844)893-1206

Questions?
- Contact the Blue Shield Home-Based Palliative Care team at bscpalliativecare@blueshieldca.com or
- Visit the Palliative Care page on Provider Connection
Advance care planning for providers & patients

- Ariadne Labs framework / Serious Illness Conversation Guide and What Matters to Me workbook

Ariadne Labs: What Matters to Me Workbook

Ariadne Labs: Serious Illness Conversation Guide