Advance Care Planning: Starting the Conversation

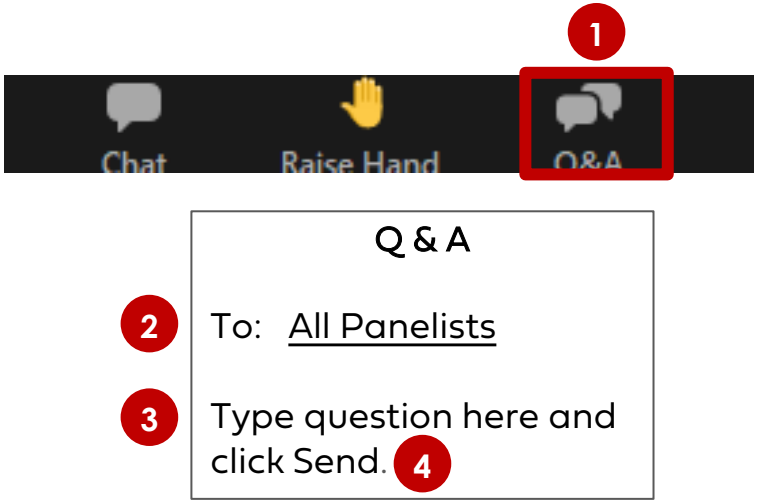
Agenda

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

Use Q&A for questions and technical help

1. Click **Q&A** on the bottom menu bar
2. Select **All Panelists**
3. Type your question
4. Click **Send**



Click **Live Transcript** for closed captioning

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

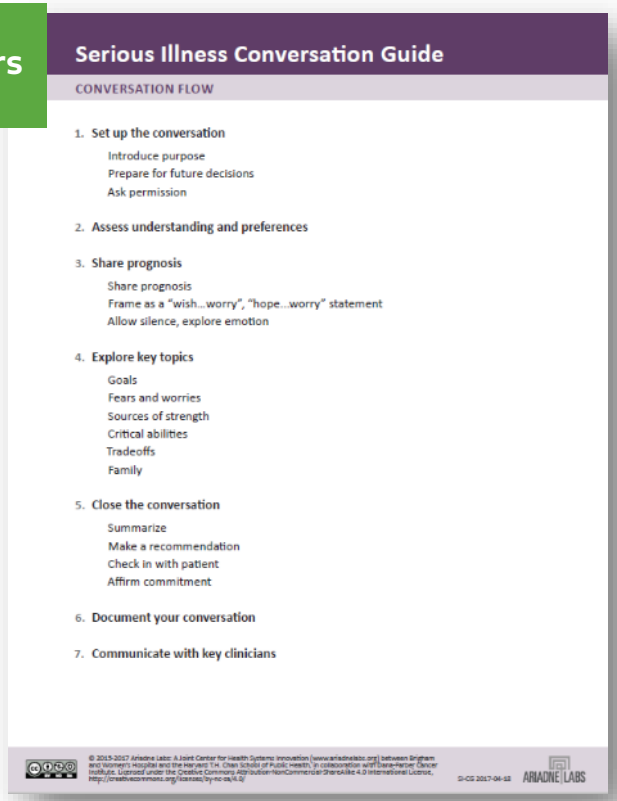
What is advance care planning?

- 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

For providers



Serious Illness Conversation Guide

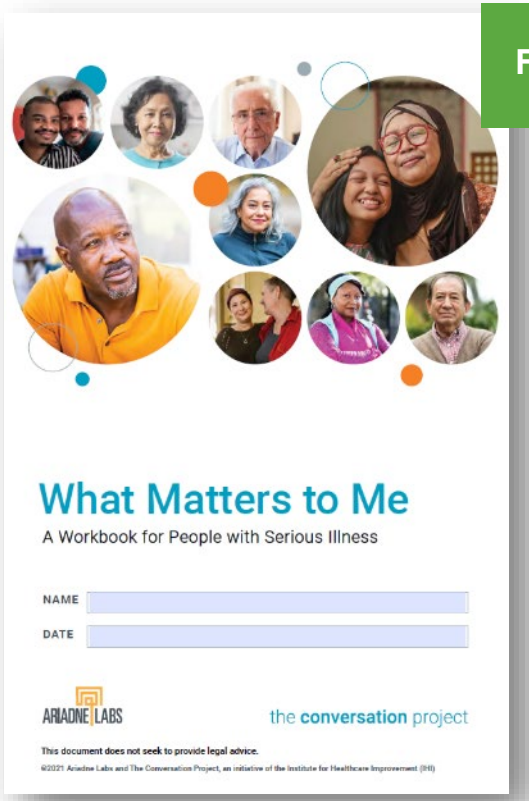
CONVERSATION FLOW

1. Set up the conversation
   - Introduce purpose
   - Prepare for future decisions
   - Ask permission
2. Assess understanding and preferences
3. Share prognosis
   - Share prognosis
   - Frame as a "wish...worry", "hope...worry" statement
   - Allow silence, explore emotion
4. Explore key topics
   - Goals
   - Fears and worries
   - Sources of strength
   - Critical abilities
   - Tradeoffs
   - Family
5. Close the conversation
   - Summarize
   - Make a recommendation
   - Check in with patient
   - Affirm commitment
6. Document your conversation
7. Communicate with key clinicians

ARIADNE LABS

[Ariadne Labs: Serious Illness Conversation Guide]

For patients



What Matters to Me

A Workbook for People with Serious Illness

NAME

DATE

ARIADNE LABS

the conversation project

This document does not seek to provide legal advice.

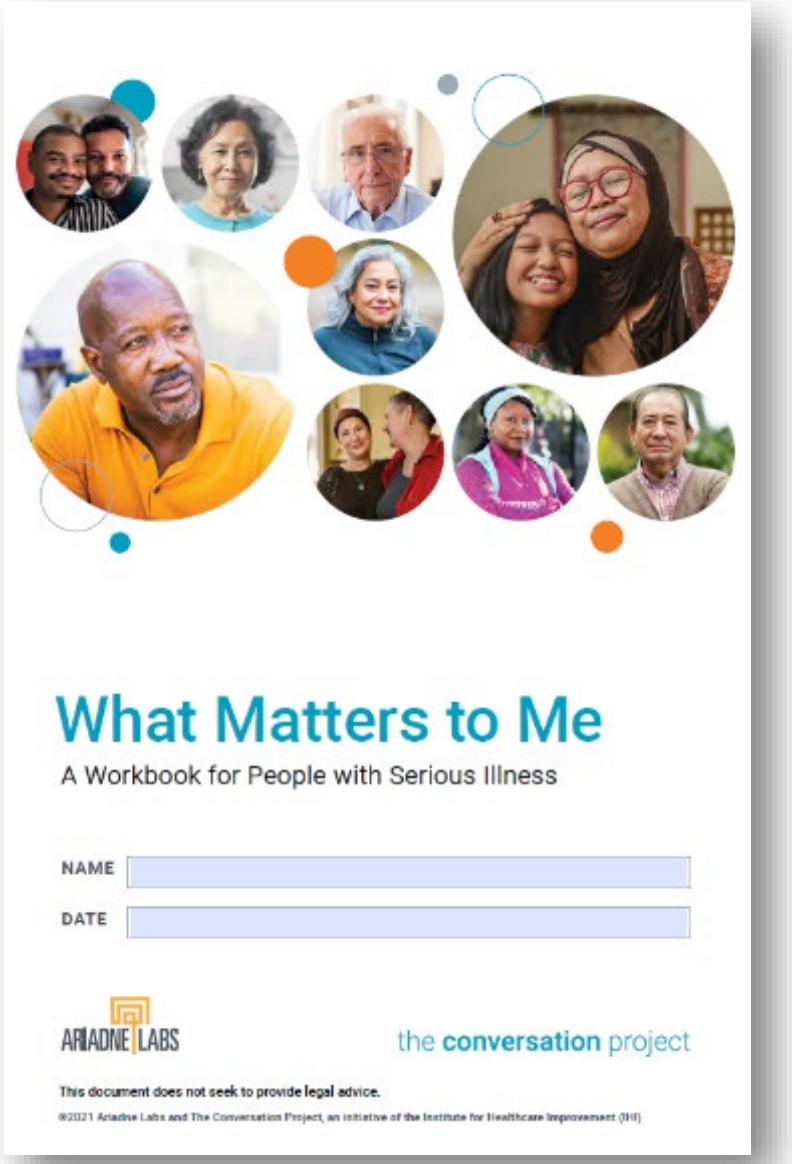
[Ariadne Labs: What Matters to Me Workbook]

and linked to Blue Shield

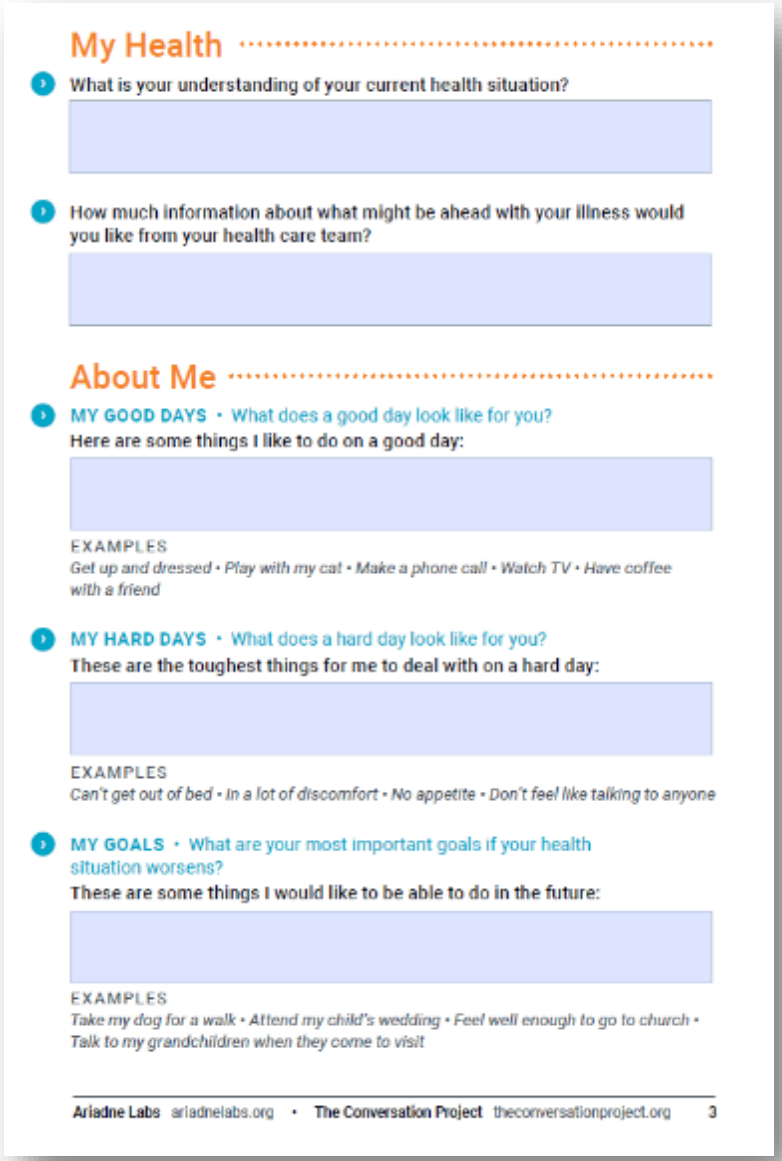
[Palliative Care page]

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

What is your understanding of your current health situation?

How much information about what might be ahead with your illness would you like from your health care team?

About Me

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

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

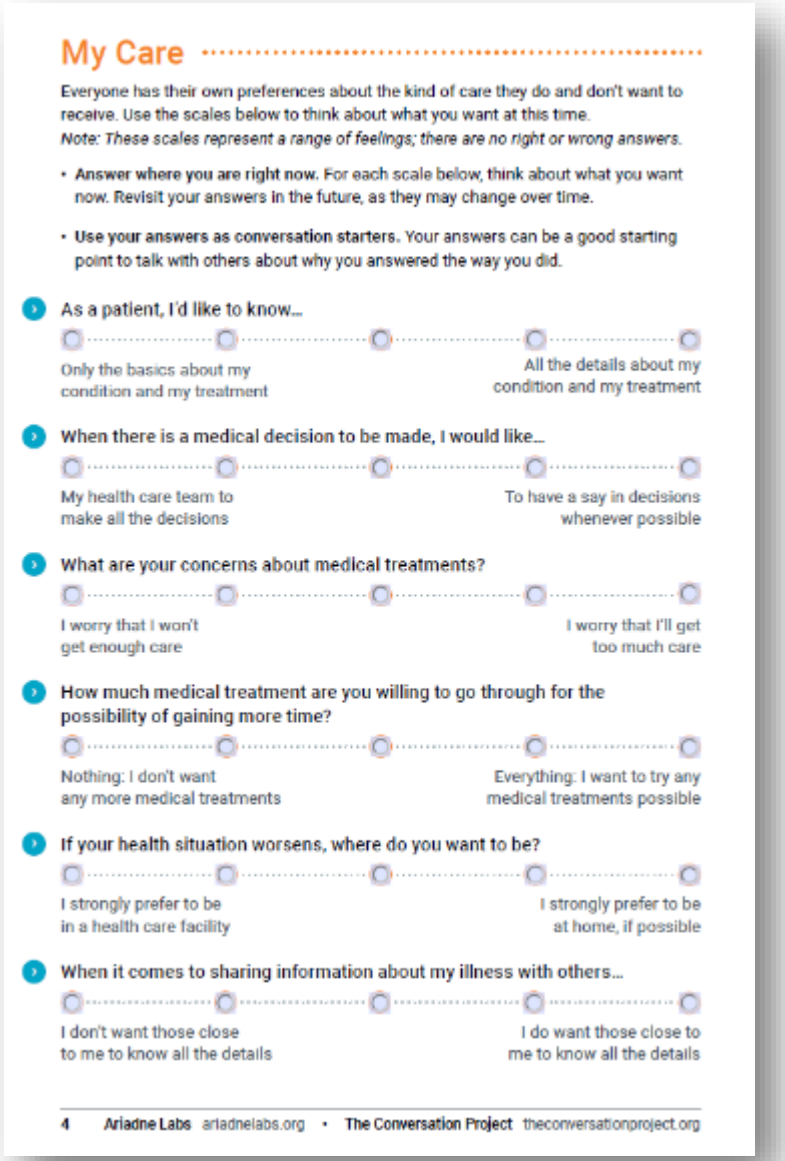
Can't get out of bed • In a lot of discomfort • No appetite • Don't feel like talking to anyone

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

Everyone has their own preferences about the kind of care they do and don't want to receive. Use the scales below to think about what you want at this time.

Note: These scales represent a range of feelings; there are no right or wrong answers.

- **Answer where you are right now.** For each scale below, think about what you want now. Revisit your answers in the future, as they may change over time.
- **Use your answers as conversation starters.** Your answers can be a good starting point to talk with others about why you answered the way you did.

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

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

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

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

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

I strongly prefer to be in a health care facility — I strongly prefer to be at home, if possible

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)

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?

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")

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.

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

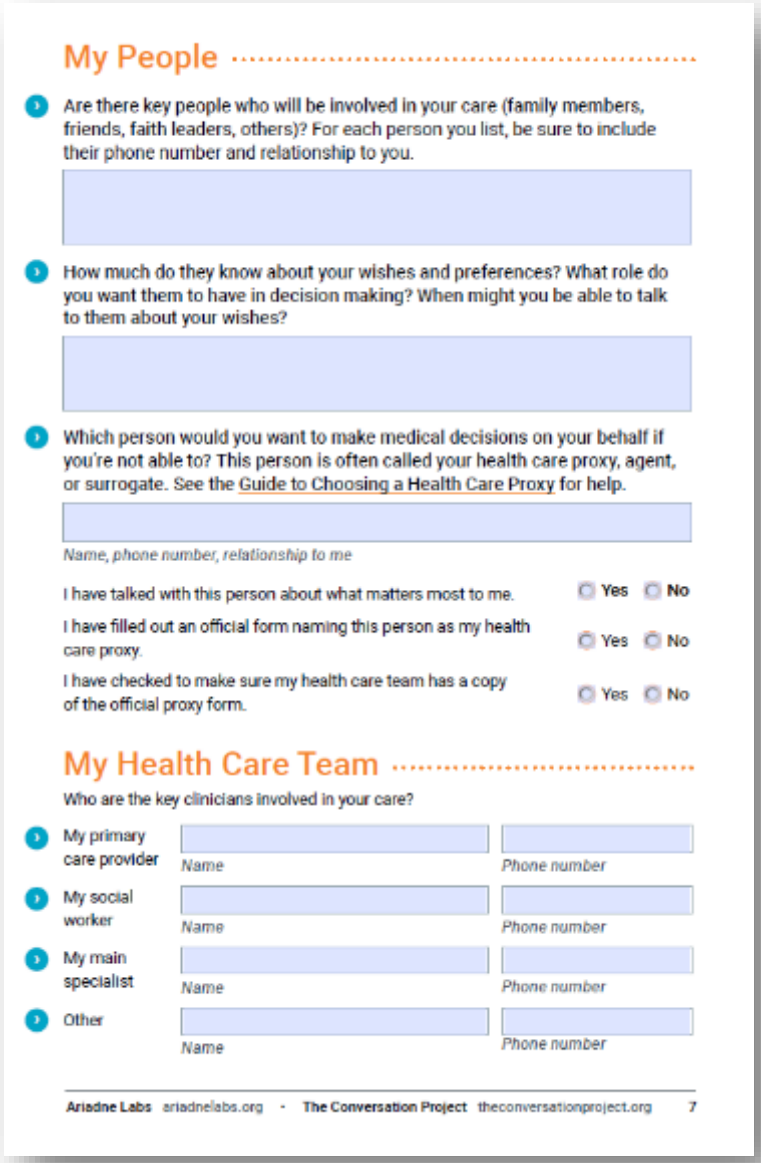
Is there anything else you want to make sure your family, friends, and health care team know about you and your wishes and preferences for care if you get sicker?

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

- 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.
- 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?
- 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

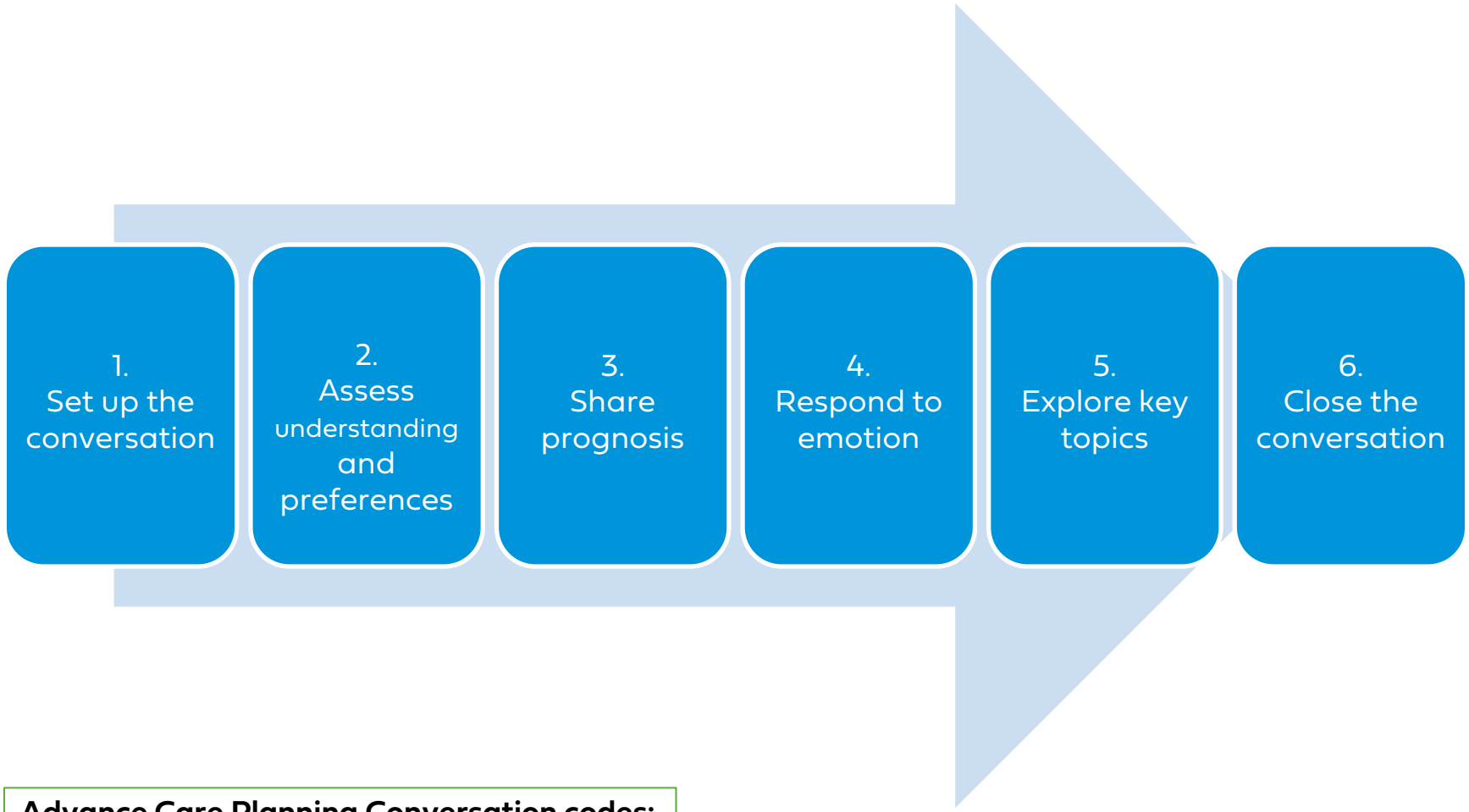
I have talked with this person about what matters most to me.	Yes	No
I have filled out an official form naming this person as my health care proxy.	Yes	No
I have checked to make sure my health care team has a copy of the official proxy form.	Yes	No

My Health Care Team

Who are the key clinicians involved in your care?

	Name	Phone number
My primary care provider		
My social worker		
My main specialist		
Other		

Advance care planning conversation steps



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."

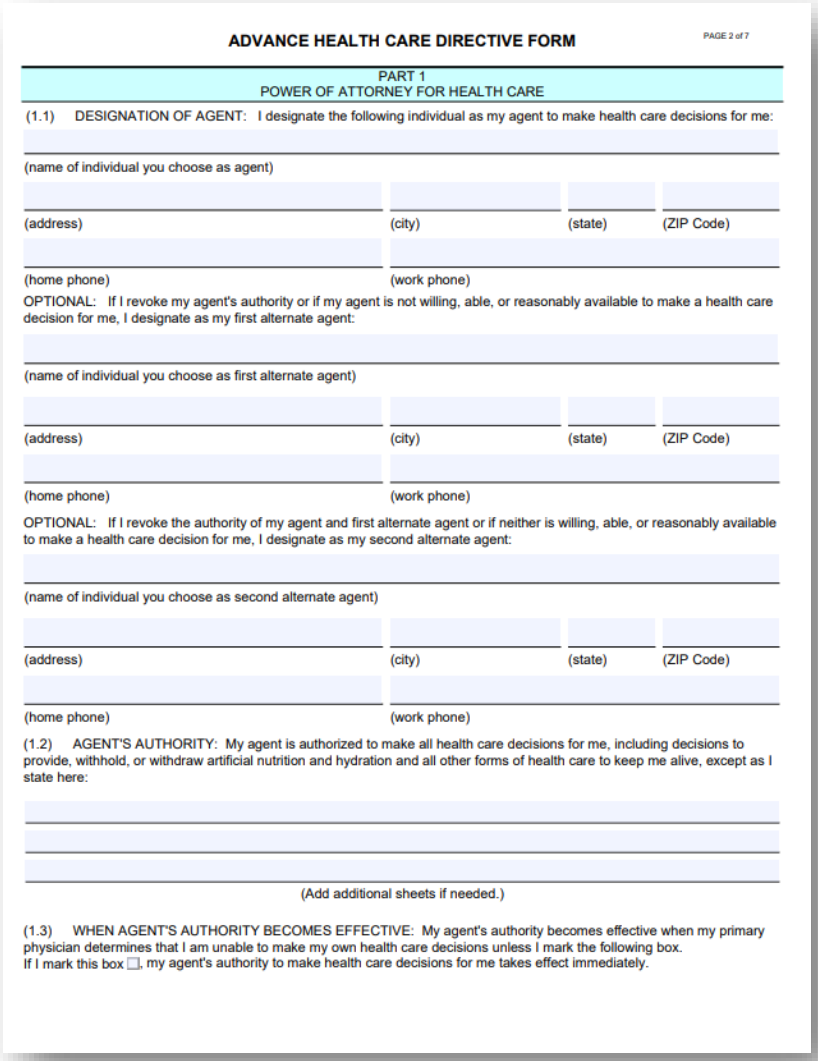
- Check in with patient

"How does this plan seem to you?"

- Affirm commitment

"I will do everything I can to help you through this."

Document your conversation



ADVANCE HEALTH CARE DIRECTIVE FORM

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PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

(name of individual you choose as agent)

(address) (city) (state) (ZIP Code)

(home phone) (work 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:

(name of individual you choose as first alternate agent)

(address) (city) (state) (ZIP Code)

(home phone) (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:

(name of individual you choose as second alternate agent)

(address) (city) (state) (ZIP Code)

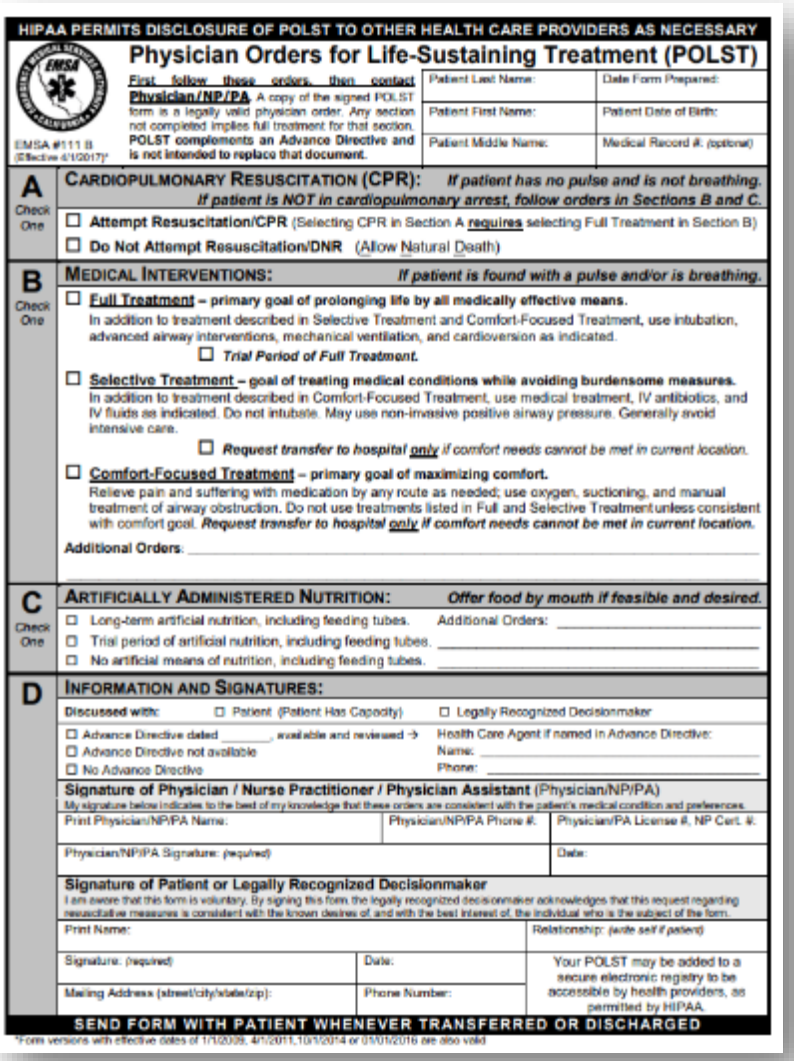
(home phone) (work phone)

(1.2) 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.)

(1.3) 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.

California Advanced Health Care Directive



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

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B (Effective 4/1/2017)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name: | Date Form Prepared:
Patient First Name: | Patient Date of Birth:
Patient Middle Name: | Medical Record #. (optional)

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B Check One — **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders:

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders:
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

D **INFORMATION AND SIGNATURES:**

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:
☐ Advance Directive not available Name:
☐ No Advance Directive Phone:

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name: | Physician/NP/PA Phone #. | Physician/PA License #, NP Cert. #.
Physician/NP/PA Signature: (required) | Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name: | Relationship: (write self if patient)
Signature: (required) | Date:
Mailing Address (street/city/state/zip): | Phone Number:

Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 05/01/2016 are also valid.

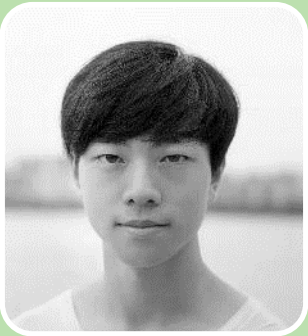
Physician Orders for Life-Sustaining Treatment (POLST)

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.

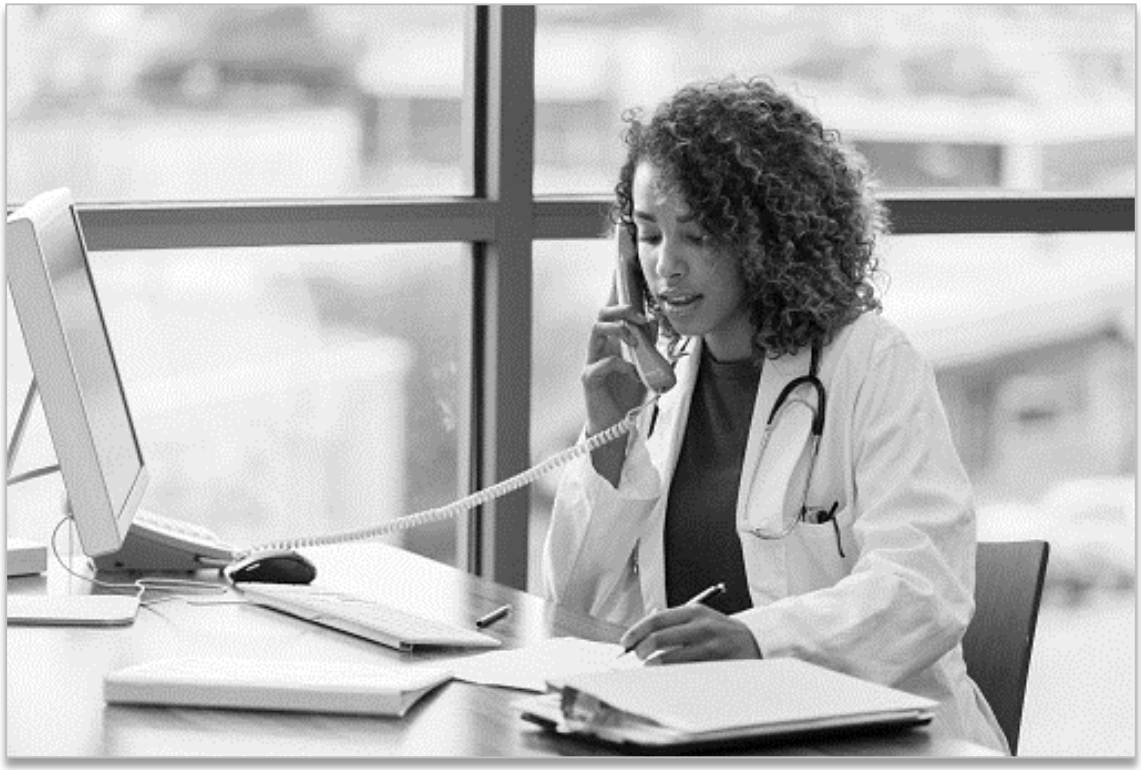


Voicing My Choices

- 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.



Q&A

1. Click **Q&A** on the bottom menu bar
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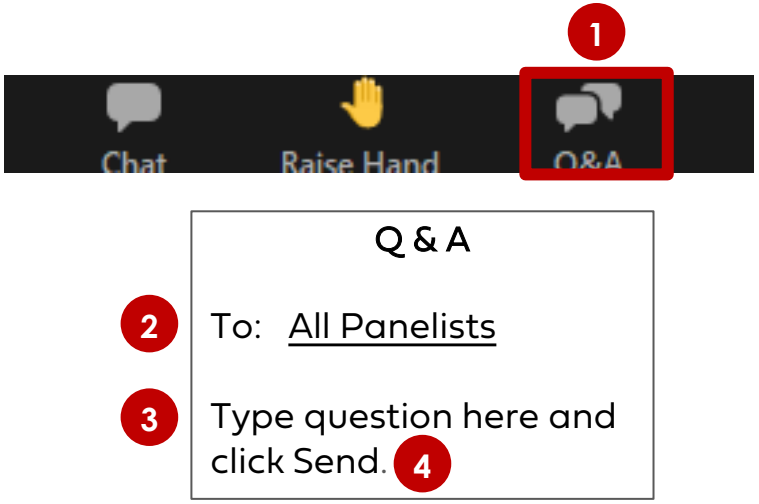


HBPC Program overview

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

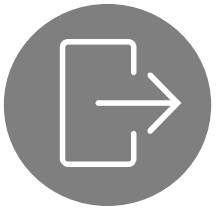
Help with treatment decisions

Help with coordinated medical care

Help with pain and other symptoms

Support for family

Referrals to Blue Shield and community resources



Provided in settings throughout California, wherever the member needs or wants:

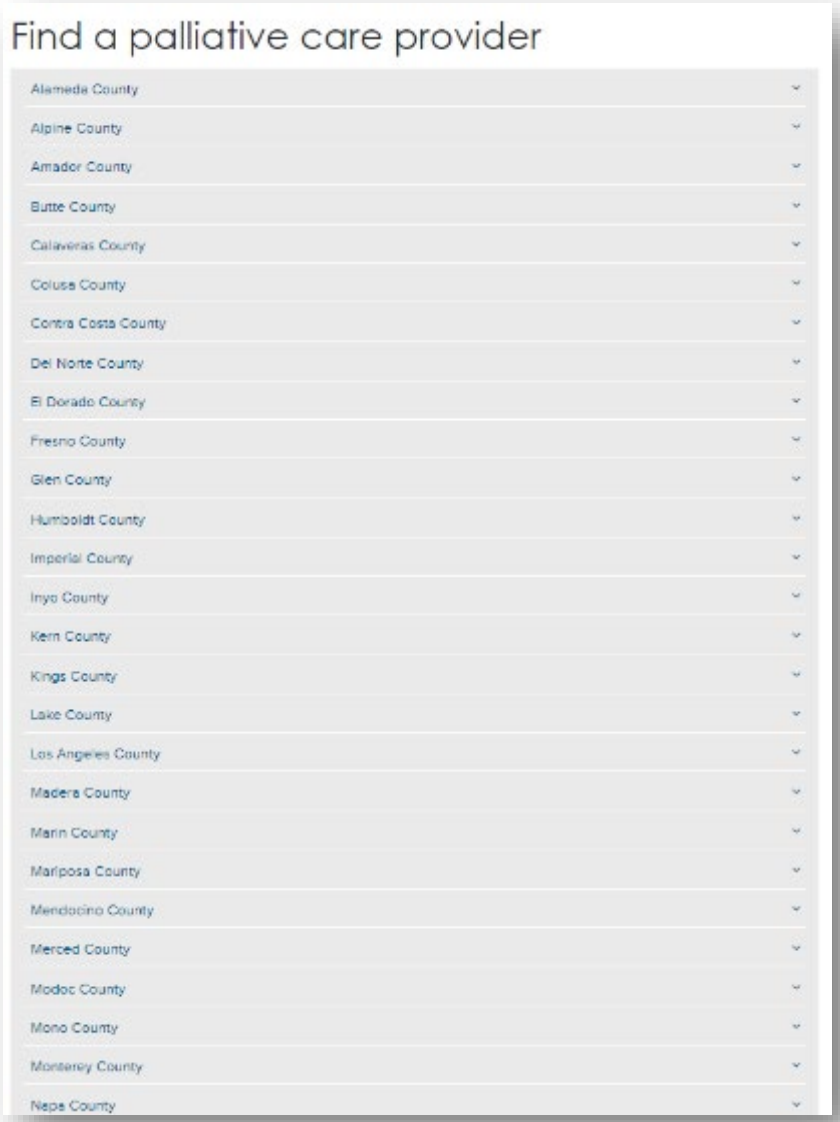
- At home (in 40 counties)
- Via phone or video in rural areas (in 18 counties)
- In skilled nursing facilities (SNF)

* 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

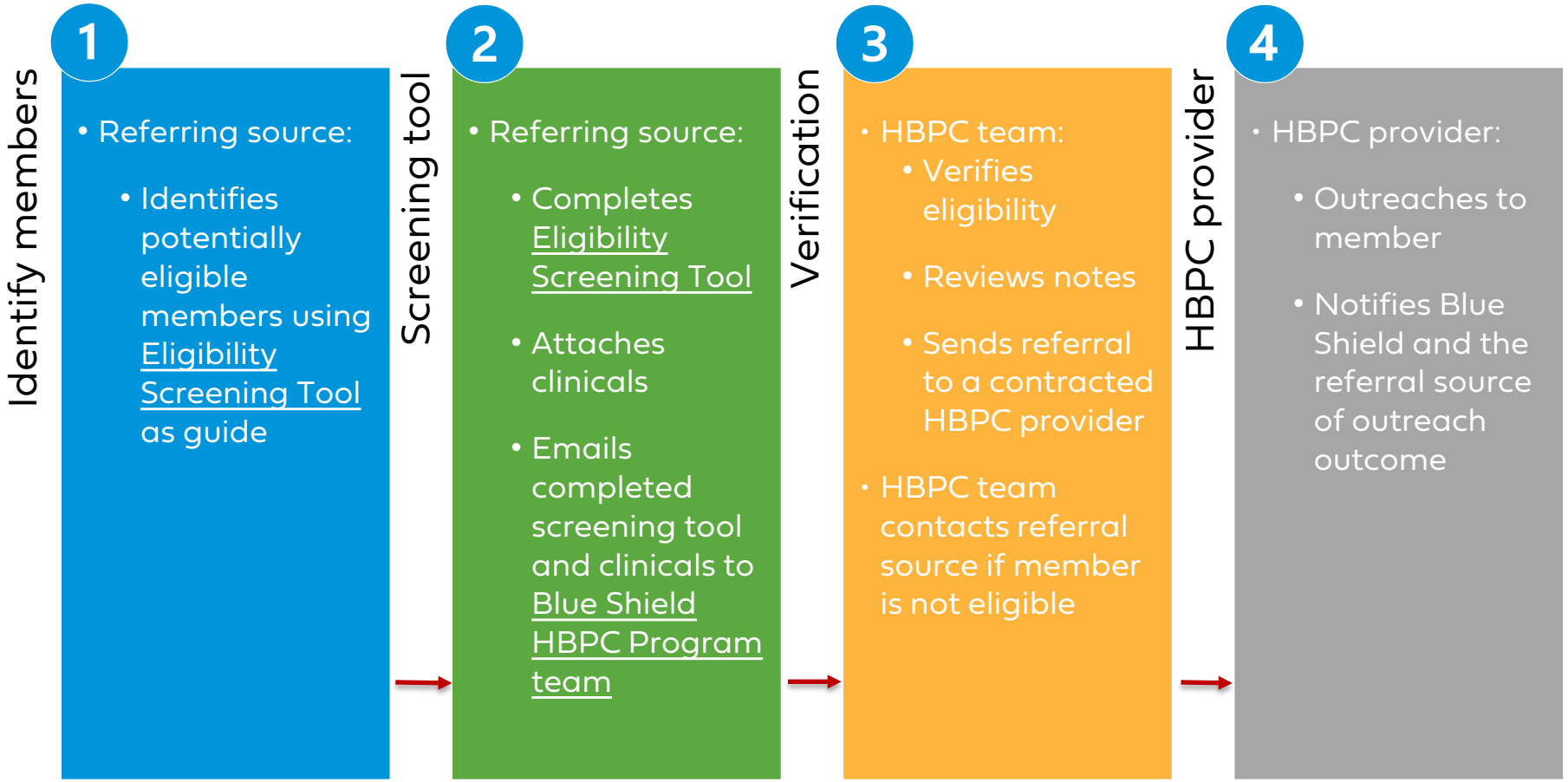
HBPC Program provider listing



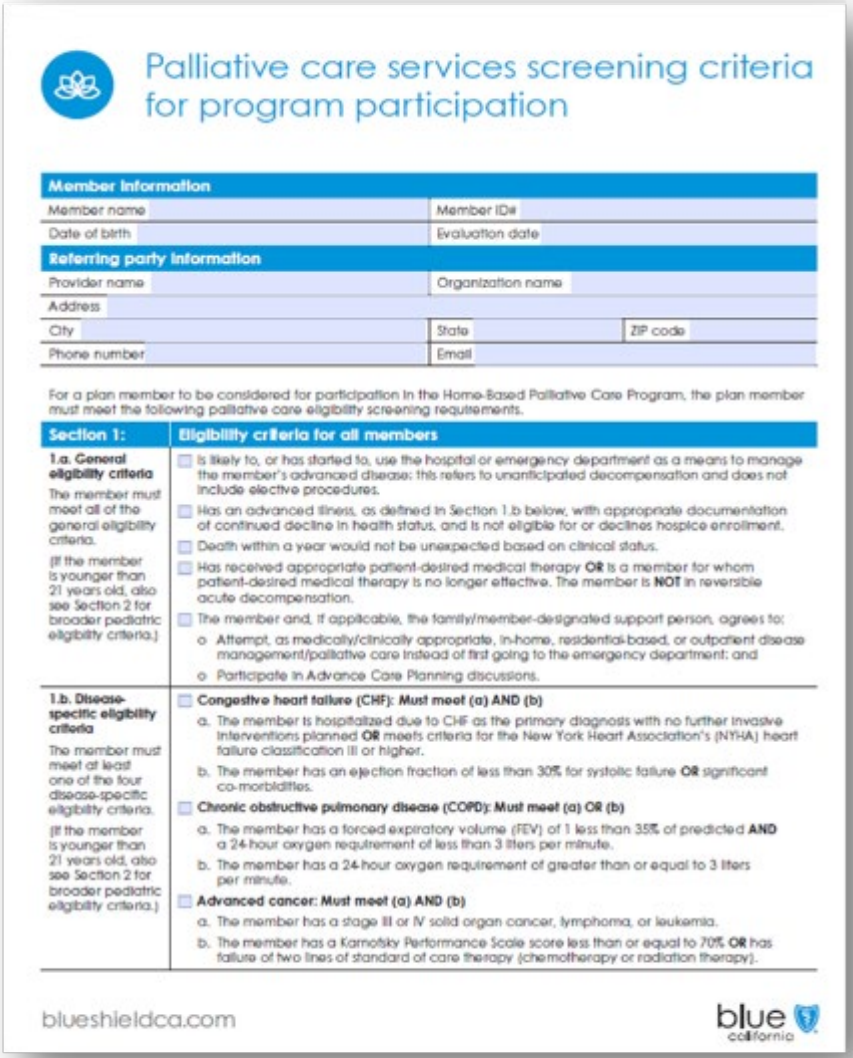
HBPC Program provider listing by county located on Provider Connection – no login required.

www.blueshieldca.com/palliativecare

Referral process



Eligibility Screening Tool



Palliative care services screening criteria for program participation

Member information			
Member name		Member ID#	
Date of birth		Evaluation date	
Referring party information			
Provider name		Organization name	
Address			
City		State	ZIP code
Phone number		Email	

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.a. General eligibility criteria The member must meet all of the general eligibility criteria. (If the member is younger than 21 years old, also see Section 2 for broader pediatric eligibility criteria.)	☐ Is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures. ☐ Has an advanced illness, as defined in Section 1.b below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment. ☐ Death within a year would not be unexpected based on clinical status. ☐ Has received appropriate patient-desired medical therapy **OR** is a member for whom patient-desired medical therapy is no longer effective. The member is **NOT** in reversible acute decompensation. ☐ The member and, if applicable, the family/member-designated support person, agrees to: o Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and o Participate in Advance Care Planning discussions.
1.b. Disease-specific eligibility criteria The member must meet at least one of the four disease-specific eligibility criteria. (If the member is younger than 21 years old, also see Section 2 for broader pediatric eligibility criteria.)	☐ **Congestive heart failure (CHF): Must meet (a) AND (b)** a. 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) heart failure classification III or higher. b. The member has an ejection fraction of less than 30% for systolic failure **OR** significant co-morbidities. ☐ **Chronic obstructive pulmonary disease (COPD): Must meet (a) OR (b)** a. The member has a forced expiratory volume (FEV) of 1 less than 35% of predicted **AND** a 24-hour oxygen requirement of less than 3 liters per minute. b. The member has a 24-hour oxygen requirement of greater than or equal to 3 liters per minute. ☐ **Advanced cancer: Must meet (a) AND (b)** a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia. b. The member has a Karnofsky Performance Scale score less than or equal to 70% **OR** has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

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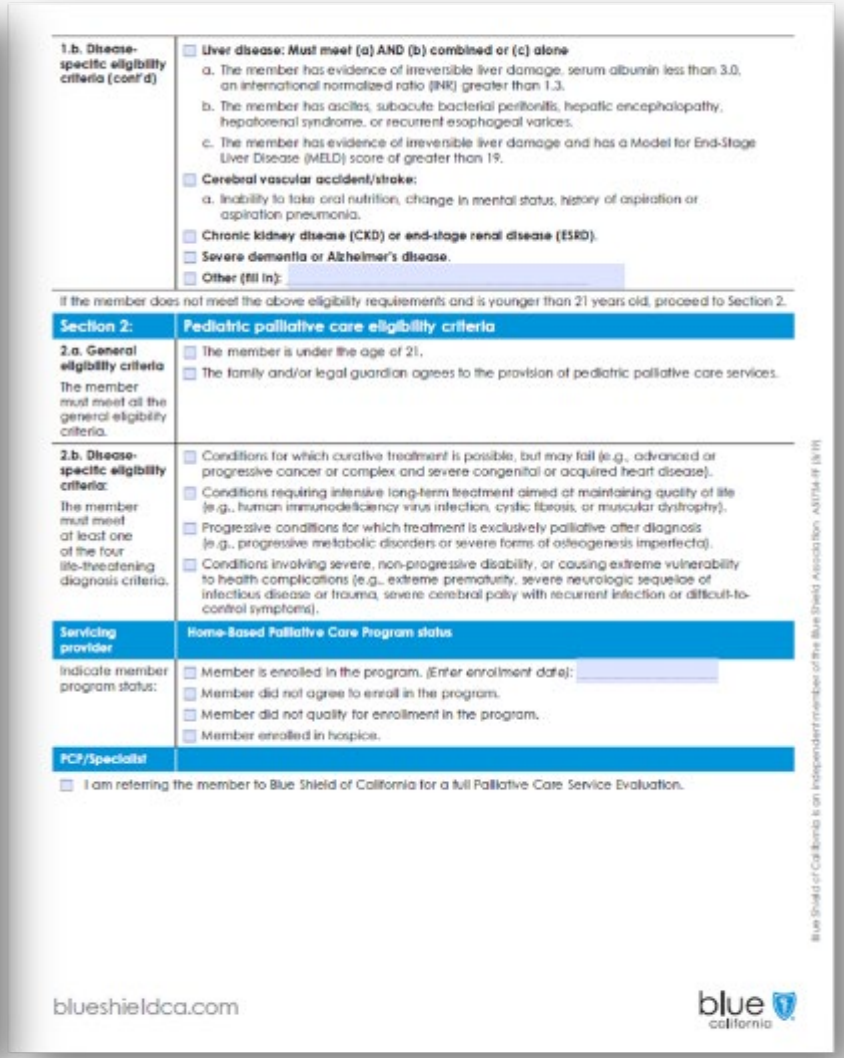

1.b. Disease-specific eligibility criteria (cont'd)	☐ **Liver disease: Must meet (a) AND (b) combined or (c) alone** a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, an international normalized ratio (INR) greater than 1.3. b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices. c. The member has evidence of irreversible liver damage and has a Model for End-Stage Liver Disease (MELD) score of greater than 19. ☐ **Cerebral vascular accident/stroke:** a. Inability to take oral nutrition, change in mental status, history of aspiration or aspiration pneumonia. ☐ **Chronic kidney disease (CKD) or end-stage renal disease (ESRD).** ☐ **Severe dementia or Alzheimer's disease.** ☐ **Other (fill in):**

If the member does not meet the above eligibility requirements and is younger than 21 years old, proceed to Section 2.

Section 2:	Pediatric palliative care eligibility criteria
2.a. General eligibility criteria The member must meet all 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.b. Disease-specific eligibility criteria: The member must meet at least one of the four life-threatening diagnosis criteria.	☐ Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease). ☐ 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 after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta). ☐ 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	**Home-Based Palliative Care Program status**
Indicate member 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.
PCP/Specialist	

☐ I am referring the member to Blue Shield of California for a full Palliative Care Service Evaluation.

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Eligibility Screening Tool

Working together

Referrals?

Complete the Eligibility Screening Tool and email or fax to the Blue Shield Home-Based Palliative Care Team:

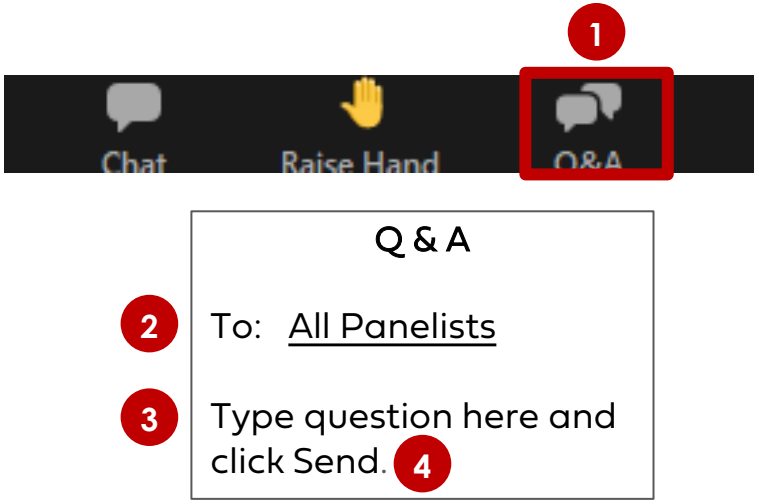
- Email: bscpalliativecare@blueshieldca.com
- Fax: (844)893-1206

Questions?

- Contact the Blue Shield Home-Based Palliative Care team at bscpalliativecare@blueshieldca.com **or**
- Visit the Palliative Care page on Provider Connection

Q&A

1. Click **Q&A** on the bottom menu bar
2. Select **All Panelists**
3. Type your question
4. Click **Send**

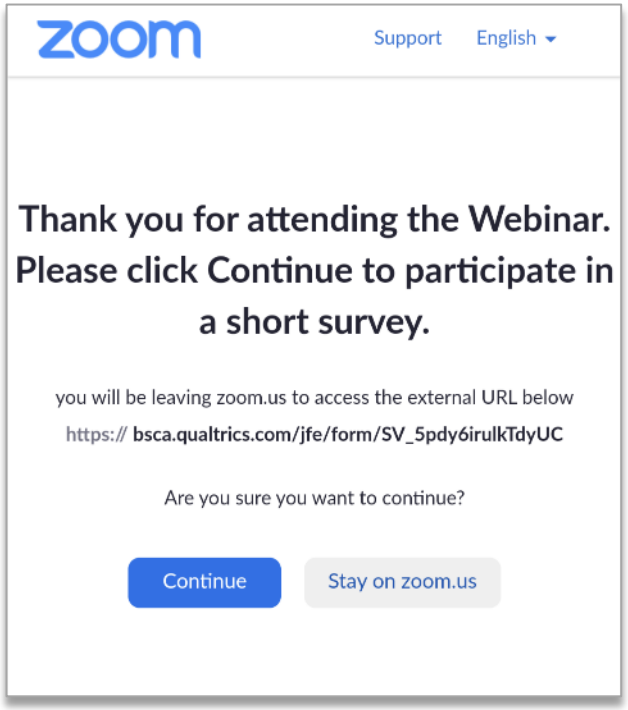


Thank you for attending!

Please complete the evaluation survey after the webinar. Your feedback is important!

Click Continue to access the survey – it takes approximately 3 minutes to complete.

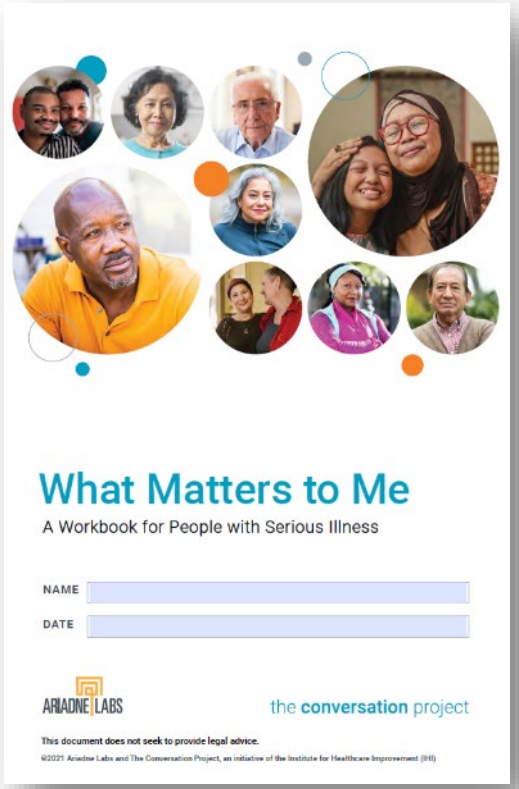
This presentation and a link to the recording will be emailed to you within five (5) business days.



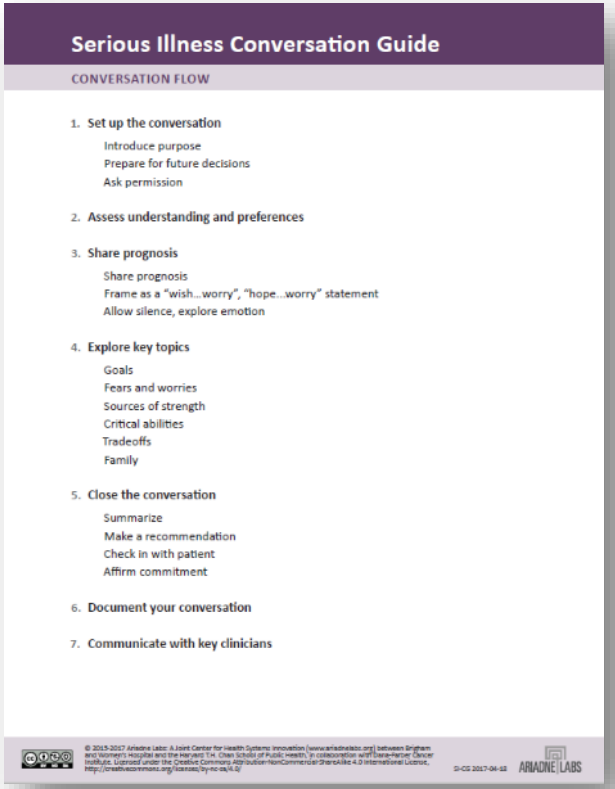
Thank you

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]