A HEALTH SYSTEM’S TRANSFORMATIONAL GOAL FOR ADVANCE CARE PLANNING

Wellspan Health: A Regional Integrated Health System in South Central Pennsylvania

Presented By:
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OBJECTIVES:

1. Gain knowledge of two or more advance care planning (ACP) interventions that demonstrate patient centered care practices

2. Gain knowledge of three system changes that impact the long term sustainability of ACP outcomes

3. Understand ways to utilize collaborative principles across organizations and communities that improve access to ACP

4. Understand ways to customize and utilize the EHR to document conversations with patients about ACP before legal documents are available

OUR JOURNEY

• What caused us to consider changing our approach to advance care planning?

• How did we start a system initiative?
OUR HORIZON PLANNING® JOURNEY

Leadership buy in and support

<table>
<thead>
<tr>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>FY18</th>
<th>FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation for system-wide effort</td>
<td>Preparation for pilot projects</td>
<td>Pilot Project Launched</td>
<td>Expansion to new sites</td>
<td>Scale to multiple sites and entities across the continuum</td>
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- **Blue Book Objective:**
  - Successful pilot in 3 WMG Practices

- **Infrastructure:**
  - Addition of HP/ACP coordinator

- **Process:**
  - Dynamic Process which takes place over time

- **FOCUS:**
  - Conversations with multiple parties – Family, Proxy, Health Care team

- **TOOLS AND TRAINING:**
  - Enhanced tools and training

- **CULTURE:**
  - Focused on outcome of conversation and wishes honored.
  - Reduces moral distress, less anxiety and depression for families, and higher use of palliative/hospice care.

**Why Do It Differently?**

<table>
<thead>
<tr>
<th>Before</th>
<th>Now</th>
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</thead>
<tbody>
<tr>
<td><strong>APPROACH</strong></td>
<td>• Siloed Approach</td>
</tr>
<tr>
<td><strong>STRUCTURE</strong></td>
<td>• Limited structure</td>
</tr>
<tr>
<td></td>
<td>• Individual bright spots</td>
</tr>
<tr>
<td><strong>RESPONSIBILITY</strong></td>
<td>• Physician/APC responsibility</td>
</tr>
<tr>
<td><strong>PROCESS</strong></td>
<td>• Static</td>
</tr>
<tr>
<td><strong>FOCUS</strong></td>
<td>• Documentation</td>
</tr>
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<td><strong>CULTURE</strong></td>
<td>• Focused on numbers on file and not on follow up and use.</td>
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<td></td>
<td>• Results are increased conflict at end of life, moral distress for health care staff, and high cost of unnecessary treatment.</td>
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- **APPROACH:**
  - Collaborative Group
  - Vision Statement
  - Strategic Plan
  - Training in Respecting Choices® model
  - Employee Engagement with Hello Game®

- **CULTURE:**
  - Focused on numbers on file and not on follow up and use. | • Focused on outcome of conversation and wishes honored. |
  - Results are increased conflict at end of life, moral distress for health care staff, and high cost of unnecessary treatment. | • Reduces moral distress, less anxiety and depression for families, and higher use of palliative/hospice care. |
STRATEGIC APPROACH TO ADVANCE CARE PLANNING

- **Shared Mental Model → The Importance Of The Conversation**
- **Team Training → Messages In Sync, Materials The Same**
- **Integration into entire health system → County Wide Approach:** Not Just WellSpan Medical Group (Primary care)

Horizon Planning – providing a consistent message in all phases of care

PCP

Specialist

Acute Care Hospital

Skilled Nursing Facility

Home Health

Hospice/Palliative Care
HORIZON PLANNING – PHASES OF LIFE

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Phase 4</th>
<th>Phase 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy or with a curable condition</td>
<td>Early onset, chronic conditions</td>
<td>Progressive, frequent complications</td>
<td>Hospice eligible</td>
<td>Family Bereavement</td>
</tr>
</tbody>
</table>

- Planning should begin at earliest phase with a conversation, and continue throughout life.
- The extent of planning and the conversation will be different in each phase.

WHAT A SYSTEM’S APPROACH OFFERS

- Ensure conversations about an individual’s preferences and hopes are happening early and often in conjunction with a care provider.
- Ensure a standard approach to having these conversations.
- Include the patient’s family in these discussions.
- Create a care experience for patients that is well planned.
- Diminish or eliminate the moral distress experienced by family who must make healthcare decision when they do not know what the patient would want.
HOW DOES A TEAM APPROACH WORK BETTER?

- Team Approach
- Not just Physician responsible for the conversation
- Multi-step process normalizing conversation
- Extent of conversation is different

HORIZON PLANNING® VISION AND STRATEGIES

OUR VISION:
An empowered community that discusses death openly across all ages and backgrounds. Conversations about dying are not feared and avoided but cherished. Each individual’s wishes are known, respected and honored so people live and die with dignity.

KEY STRATEGIES:
OUR GOALS

• **For Patients:** Ensure each patient considers and creates a plan for aging, tragedy and/or illness trajectory according to their own wishes and preferences.

• **For Communities and Families:** Educate, engage and provide tools for having conversations about aging, tragedy and/or illness trajectory earlier in life and correct misconceptions which exist.

• **For Care Team:** Develop care team members with the skills to guide patients in appropriate planning conversations and to honor the wishes of patients as discussed and documented.

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**Horizon Planning® Workflow for Primary Care Practice**

**Day of Patient Visit**

- Introduces Horizon Planning® while rooming the patient.
- Completes Advance Care Planning (ACP) Note in Epic to document patient conversation and outcome.

**1-2 Weeks Later**

- Discusses Horizon Planning® with patient and gives them:
  - Horizon Planning® Patient Instructions,
  - Advance Care Planning Step-by-Step Guide,
  - Horizon Planning® brochure,
  - Five Wishes® booklet, and
  - Patient Education Guide on End-of-Life Treatments Task the health coach for follow-up and indicates Phase of Life 1-4 for patient.
- Completes Advance Care Planning (ACP) Note in Epic to document patient conversation and outcome.

**At a Later Date**

- Contacts Patient.
- Completes Horizon Planning® Advance Care Planning (ACP) Note in Epic.
- Completes Phase of Life 1-4 templates depending on phase established by physician/APC.
- Requests patient to complete and return the Five Wishes® booklet. When returned, review to confirm documents were signed and witnessed appropriately.
- Add Z7b.92 OK 1507656 Problem List code “Advance Directive - Copy within Patient Chart” once Five Wishes or any living will is approved and scanned into EPIC. Remains in Chart.

- POA sends copy of Five Wishes® to Health Coach/Alternative Clinical Staff for review and approval before scanning.
- Or check that Living Will is signed and dated, and UPOA is signed and dated.
- POA/Medical Assistant follow workflow for scanning Advance Directives.

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Once the Horizon Planning® ACP Note is complete, it is considered that you have completed this portion of the Horizon Plan®.
Horizon Planning® Workflow for Good Samaritan Hospital

Upon Hospital Admission

CARE MANAGEMENT
- Look at previous ACP notes for patient to review any history through Notes tab or Snapshot/Plan of Care.
- Introduces Horizon Planning® concepts with patient and discusses need and value of Advance Care Planning conversations.
- Answers general questions and provides Horizon Planning brochure only.
- Completes Horizon Plan/Advance Care Planning Note in Epic
- Adds Five Wishes® Advance Directive problem to active problem list; 271.89; ID # 200135
- Sends consult to Spiritual Care if requested by the patient. Nurse can also send consult.

CARE MANAGEMENT
- Look at previous ACP notes for patient to review any history through Notes tab or Snapshot/Plan of Care.
- Introduces Horizon Planning® packet with patient and reinforces need and value of Advance Care Planning conversations.
- Completes Advance Care Planning note in Epic regarding selected patient, and their intent in Horizon Planning?
- Sends consult to Spiritual Care if requested by the patient. Nurse can also send consult.

Day of Discharge

ATTENDING PHYSICIAN/HOSPITALIST
- Make this a standard conversation on discharge.
- Look at previous ACP notes for patient to review any history through Notes tab or Snapshot/Plan of Care.
- If admission remains active in Code status for EOL issues, then send consult to Care Management for follow-up on Horizon Planning.
- At discharge, discusses Horizon Planning® with patient and encourages them to review materials and discuss with family and PCPs.
- Documents in ACP note in EPIC conversation with patient. Can use Briggs mnemonic to track future care.
- Encourage follow-up with patient’s PCP.
- Answers any questions about health condition and possible end-of-life treatment options.

DISCHARGE NURSE
- Follow workflow for sending Advance Directives
- Original Five Wishes® booklet returned to patient

At a Later Date

PATIENT RETURNS THE FIVE WISHES® BOOKLET TO MEDICAL RECORDS OR TO PCP
- Follow workflow for sending Advance Directives
- Original Five Wishes® booklet returned to patient

Once the Horizon Planning® Template and Note is complete, it is considered that you have completed this portion of the Horizon Plan®. Any position can discuss the questions in the Phase 1 through 4 templates with a patient to create “Living Will” type answers in the EHR before documents are received.

Horizon Planning® Toolkits

For Patients

For Staff
MAXIMIZING THE EHR FOR ACP

Leveraging EPIC

- ACP Page
- ACP Notes
- ACP Templates
- Epic Care Link
- Progress Reports
- AVS Summary
- My WellSpan Portal

HONORING THE PATIENT’S WISHES

Click ACP Notes in the left menu. Click the blue Create ACP Note to create a new Advanced Care Planning note. If notes are made in any other section they will not show up as ACP Notes, and will be lost in the chart. This step of documenting in “Create ACP Note” is extremely important.

Click Insert SmartText "Insert SmartText" to search for template.

- Type “Advance” to search for Horizon Planning Phase templates and press Enter.
- Click to select appropriate Phase template (Phase 1-4), click Next.

Advance Directive Scanning through the Document Table

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ENGAGING THE COMMUNITY

• HELLO GAME®
QUESTIONS AND DISCUSSION

THANK YOU
Dr. Vipul Bhatia, MD, MBA
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