National Share the Experience 2018

— Abstracts —

Wednesday, October 24, 2018

Plenary Session

Partners in Visioning the Future of Person-Centered Care

Bud Hammes, PhD, Executive Director, Respecting Choices; Stephanie Anderson, DNP, RN, Deputy Executive Director, Respecting Choices

Outcomes:

1. Explain how a culture of person-centered care can be achieved.
2. List three opportunities for person-centered care to spread and be sustained.
3. Describe multiple partnerships that will foster person-centered care.

Abstract Description:

This presentation will provide a brief, visionary view of person-centered care. Dr. Hammes will look at this vision by highlighting lessons and learnings from the development of Respecting Choices. Dr. Anderson will imagine the vision of person-centered care by exploring the future opportunities and possibilities. Following these brief remarks, Dr. Anderson will moderate a panel discussion to further explore the vision of person-centered care from the perspective of Respecting Choices founding organization as well as the perspectives of the Coalition to Transform Advanced Care and CTAC Innovations.

Concurrent Sessions 1

1. Innovations in Delivering First Steps ACP

Testing a Telephonic Advance Care Plan Program: A Feasibility Study

John R. Maycroft, MPP, Senior Program Manager, Optum; Rifky Tkatch, PhD, Associate Director, Optum; Jennifer Draklellis, MBA, Senior Director, UnitedHealth Care

Outcomes:

1. Describe individual's receptivity and reactions to telephonic ACP
2. Compare telephonic ACP with in-person conversations
3. Evaluate the feasibility of offering telephonic ACP as an alternative to in-person ACP conversations

Abstract Description:

The gap between the health care that individuals receive at the end of life versus the care they would have preferred could be significantly reduced with prior completion of an Advance Care Plan

(ACP). However, many individuals, including older adults, do not have an ACP. The purpose of this ACP study was to test the feasibility of a telephonically supported ACP-related discussion for older adults with a range of health status as part of a broader population health management program. Various current ACP models were considered in designing the study, which was intended to gauge interest and identify resources that may be helpful in having ACP conversations. Ten individuals participated in the research laboratory component and a debrief session afterwards. All interviews were audio and video recorded. Participants were open to having ACP conversations telephonically and having education provided, most reported they would not see a difference between a phone versus in-person discussion (n=8). Overall, participants reported the conversations elicited feelings of confidence, reassurance, and calmness. Only two participants reported feeling overwhelmed from the conversation. When asked whether they had a health advocate, all said yes and reported their intentions to speak with their health advocate in the near future. Future research should include a larger sample size and the use of a survey. This research provides data demonstrating the value of a telephonic ACP- related discussion as part of a population health program.

A Tool for Jumpstarting ACP Conversations

Carolyn C Newsom, MBA, PhD, JD, Attorney, Newsom Law

Outcomes:

1. List the key components to an ACP reflection guide to support the introduction and inviting of patients to participate in person-centered ACP conversations.
2. Describe how an ACP reflection conversation tool can be used by facilitators and physicians to engage patients in person-centered ACP conversations.

Abstract Description:

We have experienced individual discomfort when asking such questions as, "What is a good day for you?" or "What is an acceptable quality of Life?" Individuals seemed to find these exploration questions abstract and frequently ask for examples to illustrate the type of information being explored. This realization led to the creation of a *Reflection Guidelines* tool.

This presentation will describe how we developed the *Reflection Guidelines* using examples from real advance care planning conversations. Some feedback, particularly from lawyers, criticized the triviality of starting the reflections about a good day by talking about golfing or shopping. But with further exploration, conversations often morph to insights by individuals about the importance of personal connections with family and friends that provide underlying value to qualify of life.

Presenters will share their experience of how this tool might be used to support physician education and engage patients in person-centered advance care planning (ACP) conversations and increased uptake of requests for facilitates FS ACP conversation by community volunteers.

2. Leadership Strategies to Promote Person-Centered Care

Envisioning Respecting Choices as a Collaborative and Dynamic Educational Process that Reliably Results in Person-Centered Treatment Plans

Niel Rosen, JD, PhD, Program Director, Professionalism, Ethics & Humanities, Rowan University School of Osteopathic Medicine

Outcomes:

1. Explain how leadership commitment to a broad vision of person-centered patient, provider and healthcare agent education results in SDM and person-centered treatment plans.

2. Describe at least one teaching strategy that supports person-centered care programs and provides a reflection-based model for transforming culture and clinical decision-making.

Abstract Description:

This presentation draws on Dr. Rosen's experience as a medical educator: teaching advance care planning (ACP) in grand rounds, during workshops, and to medical students. In each of these contexts, Dr. Rosen frames ACP in a way that resonates with how clinicians understand the nature of their work and, more importantly, their commitments as healthcare professionals to person-centered decision-making. This presentation lays out that framework by telling the story of RC's success. It will be helpful to healthcare leaders because leaders frequently tell stories to communicate their vision for organizational change.

RC's mission of transforming healthcare requires developing a framework broader than EOL considerations. Clearly, person-centered care provides such a framework: "an authentic clinician-patient relationship that supports collaborative SDM and ACP in which care desired is in concordance with care provided." This statement reflects a broadening of the picture: SDM provides the framework for understanding ACP. Dr. Rosen lays out an even broader framework for understanding ACP, SDM and RC's mission of transforming healthcare. RC succeeds because it educates patients, their agents, and their healthcare team. Although the role of teacher and learner changes as the group's focus shifts, everyone comes to understand the same elements: the patient's condition, including what is likely to happen without treatment; the burdens and benefits of potential treatments; and what matters most to the patient. This shared understanding reliably produces person-centered ACP and SDM. It is the story of RC as a dynamic and collaborative educational process.

A Health System's Transformational Goal for Advance Care Planning

Roberta L. Geidner, MA, Coordinator, WellSpan Health; Vipul Bhatia, MD, MBA, Medical Director, Post-Acute Services and Clinical Lead – Horizon/Advance Care Planning, WellSpan Health

Outcomes:

1. List the collaborative principles used across organizations and communities that improve access to ACP and SDM.
2. Describe strategies to customize and utilize the EHR to document conversations with patients about ACP and SDM before legal documents are made available.

Abstract Description:

Four years ago, our health system researched the changes needed to the process of advance care planning. The work of Gundersen Health System and Respecting Choices® were instrumental in moving the organization to create a change in organizational culture and a systemic approach to significantly improving the engagement of patients in planning for end of life care and treatment.

The first two years involved developing a case for change, getting commitment of top leadership including Executive suite leadership and the Board of Directors, and making advance care planning a key strategic initiative for the entire health system.

Our health system's approach was not to relegate this change to Palliative or Hospice Care, but to implement a system-wide population health approach in primary care and specialty practices, acute and post-acute services, home health care, and skilled nursing facilities. Health System sponsored community coalitions adopted community health and wellness strategies for building awareness of a conversation-based approach to advance care planning.

The "First Steps® *ACP* Design and Implementation" model has been an integral tool to our work with the community and with patients. Making advance care planning conversations natural part of the provision of care cycle and life journey have been key to our efforts.

This session will demonstrate the impact of a system wide approach to changing the health system's culture in engaging patients for person-centered advance care planning much earlier in their health journey. We will provide information on system wide transformational goals, workflows, training documents, and implementation strategies as well as lessons learned and challenges overcome. With the implementation of EPIC, we will also share how our own build has enhanced the use of the EHR in documenting conversations with patients before legal documents are obtained.

3. Organizational and System Strategies Using Technology

Advance Care Planning Workflows Using Epic

Kat Thomas, BSN, RN, Quality Assurance, Epic

Outcomes:

1. List at least two unique tools available in Epic for Advance Care Planning for clinicians.
2. Self-report knowledge gained of patient facing Advance Care Planning tools available in the Epic patient portal, MyChart.
3. Describe where or how they can find additional details about Epic functionality on the Epic UserWeb.

Abstract Description:

This presentation will provide a high-level general overview of standard Epic tools and workflows for Advance Care Planning, including those within the MyChart patient portal. This session is intended for those who work for organizations already using or currently installing Epic. Attendees will have an opportunity to learn about new enhancements in Epic and discover workflows to enhance sharing of patient-centered data across disciplines and locations. The presentation will focus on tools that are currently available in the most recent version of Epic software. Following the presentation, all information shared will also be accessible from Epic's UserWeb to facilitate follow-up with the appropriate teams at each organization.

Leveraging the Electronic Health Record to Improve Access to Advance Care Planning Facilitation

Danielle A. Rathke, DNP, RN, Advance Care Planning Coordinator, Gundersen Health System

Outcomes:

1. Describe one system change used to improve access to person-centered ACP facilitation services.
2. List two strategies used to leverage the EHR to improve communication and access to ACP facilitation services.

Abstract Description:

Advance care planning (ACP) is a process intended to ensure that patients receive medical care aligned with their goals and values. It requires person-centered conversations between patients, those closest to them, and their healthcare team. Ideally, ACP is initiated early in adulthood as part of routine care. To meet the ultimate goal of ACP, systems must be created for eliciting, documenting, and using information about patient preferences. Historically, Gundersen Health

System select nurses and social workers were trained as ACP facilitators and embedded in many outpatient departments; however, as healthcare delivery evolved, facilitators found it increasingly difficult to offer ACP within the context of their daily work. Furthermore, clinicians cite lack of time and training as barriers to ACP conversations.

This presentation describes a quality improvement project intended to improve access to high-quality facilitated ACP conversations and to create clear, accurate, and complete advance directives scanned to the electronic health record (EHR). The project included implementing an efficient process for clinicians to introduce, invite, and refer patients to trained ACP facilitators. The EHR was used to support communication between the medical team and trained facilitators and to document ACP conversations in an easily retrievable format. A centralized outpatient ACP clinic was established, along with a schedulable order for ACP facilitation. Through the EHR, we can generate a report of the number of patients we see, the number seen with a surrogate, how many have a facilitation note documented, and how many conversations result in a written advance directive.

4. Customization of ACP and SDM Practices for Special Populations

Faith-Based Community Engagement to Achieve Culture Change about What Matters: Person-Centered Advance Care Planning Conversations

Sally Kaplan, Program Director, What Matters: Caring Conversations About End of Life

Outcomes:

1. Verbalize increased awareness of how to engage faith-based communities to participate in an innovative, communal, inclusive approach to person-centered advance care planning conversations.
2. Describe strategies to engage faith-based community members to participate in conversations about their goals, values and healthcare wishes to create a wider culture change around end-of-life decision-making.

What Matters, an initiative of the Jewish community of New York, was established 3-1/2 years ago by a unique consortium of a Jewish community center, a nursing home, and a rabbinical seminary with initial funding by the local Jewish community chapel. What Matters provides individuals safe, comfortable and familiar spaces to engage and educate individuals about Respecting Choices person-centered approach to value-neutral advance care planning conversations. This consortium included a wide and diverse group of synagogues, communal organizations, healthcare and academic institutions.
As a result, this initiative has been able to de-stigmatize advance care planning conversations, confront and reduce fears around end of life conversations, and provide a faith-based lens for thoughtful consideration, documentation and communication of healthcare wishes. This session will describe how we were able to engage 12 community organizations to join our growing initiative, how we evaluated success and confront challenges, what our general approach looks like, and what strategies were used for quality control and sustainability.

The Long and Winding Bumpy Road to Initiating System Change in a Diverse Widespread Healthcare System

Cindy Adams, BSN, RN, CHPN, Regional Advance Care Planning Coordinator, Baptist Health

Outcomes:

1. Describe two or more documentation elements needed to support ACP as part of a diverse healthcare system.

2. Participants will increase knowledge related to possible potholes and barriers for system-wide implementation in diverse practice setting and tools which will minimize challenges which occur.

Abstract Description:

Baptist Health Kentucky committed to implementing Respecting Choices in three distinct and culturally diverse regions of the Commonwealth of Kentucky in 2016. The implementation began with training of three organizational faculty, one from each region, in October 2016. This session will map out planning, training, and implementation strategies used in beginning waves of implementation. Presenters will point out challenges identified with specific elements of system change, such as documentation, practice culture, regional distance between sites of care, communication structure, and needed changes in workflows. They will then engage audience in how tools developed might support teams for sustainability and dissemination across other settings of care. The presentation team will share their implementation journey throughout system leadership changes, the implementation of MOST and POLST use, and improving the Epic documentation system to accommodate Advance Care Planning Conversations.

5. Optimization of ACP and SDM Reimbursement Opportunities

Update on Advance Care Planning Billing 2018: Using Lessons Learned

Phil Rodgers, MD, FAAHPM, Associate Professor, Family Medicine and Internal Medicine, University of Michigan;

Outcomes:

1. Describe the fundamentals of Medicare ACP billing codes, including updates since 2016.
2. Understand the elements of ACP billing relevant to your specific practice setting

Abstract Description:

Starting in 2016, Medicare began making payment for advance care planning services when reported with Current Procedural Terminology (CPT) codes 99497 and/or 99498. Recent data show that code reporting is increasing significantly, as providers and practices learn how to implement them into workflow. This session will briefly review the basics of the ACP codes, then describe in detail how to use them effectively, including service requirements, time thresholds, documentation and billing ACP codes in addition to other services. Special attention will be given to 'incident to' billing for teams using the Respecting Choices model, and will present some best practices already in use. Presenters will then invite questions and input from participants, to maximize interactive learning.

Workshop Sessions 1

1. POLST: Seven Deadly Sins of Improper Use

Stephanie Anderson, DNP, Deputy Executive Director, Respecting Choices; Susan E. Hickman, PhD, Professor, Indiana University School of Nursing, Co-Director, IUPUI RESPECT Center, and Associate Director, Indiana Patient Preferences Coalition; Amy Vandenbroucke, JD, Executive Director, National POLST Paradigm

Outcomes:

1. Identify at least three improper uses of the POLST form.
2. Discuss strategies to prevent or correct improper use of the POLST form.

3. Apply identified strategies to redesign systems and hardwire proper use of POLST form.

Abstract Description:

The National POLST Paradigm is a person-centered approach to end-of-life planning that emphasizes eliciting, documenting and honoring patients' treatment preferences. The Physician Orders for Life-Sustaining Treatment (POLST) form is a standardized, portable medical order set used to document and communicate these preferences. In the event of a medical emergency, the POLST form is used to guide treatment decisions so that they are concordant with a patient's documented preferences.

Fundamentally, the POLST Paradigm is not a form: it is a *process*. A narrow focus on the POLST form without attention to the supporting conversation and system can result in misuse that undermines the overall goals of the Paradigm.

This workshop will engage participants in a discussion of how to avoid the seven deadly sins of improper POLST form use, including:

1. Mandating completion of POLST forms;
2. Completing a form without meaningful conversation or without patient or surrogate knowledge;
3. Signing a POLST form for a healthy patient;
4. Giving a patient or surrogate the POLST form to complete without a conversation;
5. Never reviewing completed POLST forms;
6. Providing incentives for POLST form completion; and
7. Failing to evaluate use of the POLST Paradigm.

Participants will learn strategies to support best practices when engaging with the POLST Paradigm. This discussion will include ideas for systems redesign that ensure use of the POLST encompasses both the process of eliciting and documenting treatment preferences as well as appropriate use of the POLST form.

2. Interprofessional Collaboration: A Team Approach to Assure Person-Centered Decision Making and Enduring Conversations

Kathleen Ziemba, MSW, LCSW, Senior Faculty Consultant, Respecting Choices; Patrice Tadel, MSN, RN, Senior Faculty Consultant, Respecting Choices

Outcomes:

1. List at least two key elements of the ACP team approach that fosters competent clinical practice; clinician-patient communication, person-centered and family-oriented planning
2. Describe core concepts to build an interprofessional collaborative model fundamental to the advance care planning process, advanced illness care and care coordination
3. Identify potential barriers to interprofessional collaboration as demonstrated in a case study
4. Define three best-practice strategies that strengthen teamwork and keep individuals at the center of all care decisions

Abstract Description:

Today's complex health care environment requires skilled collaboration within interprofessional teams. The increase in patients with more complex health care needs calls for healthcare teams to engage in person-centered advance care planning (ACP) to ensure goals of care are met. There is

evidence that when health care professionals work together, patients receive better quality care and better health outcomes. The Institute of Medicine's 2015 Dying in America report identified the need to improve the competence of healthcare professionals through changes in educational and training programs that strengthen communication between the patient and clinician, collaboration and interprofessional teamwork. There is increasing awareness that clinicians, nurses, social workers, chaplains, other health professionals and students need better training in basic advance care planning competencies, especially communication skills. As innovators and leaders in ACP education and systems development, Respecting Choices has created a model that helps people and organizations produce high-quality person-centered ACP conversations within a team approach. Through interdisciplinary training and ongoing engagement, team members can relinquish some of the "hold" over this work and learn to appreciate diverse perspectives and collective value-neutrality to improve both the client and clinician experience as per the Quadruple Aim.

This session will focus on:

- Key elements of the team approach that fosters competent clinical practice, clinician-patient communication, person-centered and family-oriented planning;
- Core concepts for building an interprofessional collaborative model that is fundamental to the advance care planning process, advanced illness care and care coordination;
- Defining roles, responsibilities and level of skills different team members need;
- Examining a case from different stakeholder perspectives to elevate specific challenges and obstacles that hinder interprofessional collaboration and discuss potential solutions and strategies; and
- Best-practice strategies that strengthen interprofessional teamwork and person-centered care that keep individuals at the center of all care decisions.

3. Lessons in Leadership: Building a Multi-Stakeholder Convener Model for Person-Centered Advance Care Planning in Dayton, Ohio

Sarah Hackenbracht, MPA, Director, Greater Dayton Area Hospital Association; Abi Katz, DO, MS, Medical Director, Fidelity Health Care; Judy LaMusga, JD, Attorney and Counselor-at-Law, LaMusga Law Office; Kathleen Scheltens, PhD, Director, Premedical Programs, University of Dayton; Majorie Dowman, MD, MPA, Professor, Department of Population and Public Health Sciences, Department of Family Medicine, Boonshoft School of Medicine, Wright State University

Outcomes:

1. Analyze the roles of ACP champions within the community and healthcare organizations who are instrumental in providing executive leadership for program implementation.
2. Illustrate funding and operational strategies during early infrastructure development of a community-based advance care planning model
3. Describe strategies for constructing a model of shared ownership for ACP program sustainability within community-based implementation

Abstract Description:

Passionate community and organizational leaders brought advance care planning to the Dayton region through a partnership with Respecting Choices. By creating a multi-stakeholder convener model that encompasses health systems, hospitals, hospice, universities, medical and legal professionals, as well as community representatives, the Greater Dayton Advance Care Planning Initiative is building regional transformation to launch Decide to be Heard, the locally-branded First Steps program, and ensure advance care planning is available to all residents of the Dayton region. The Greater Dayton Area Advance Care Planning Initiative is unique in its community-led model.

Academic leaders, retired medical professionals, and current practitioners cultivated a relationship with Respecting Choices to Dayton, Ohio, and then successfully brought healthcare institutions, executive leadership, and other partner organizations to the work of advance care planning from a needs-based perspective of providing person-centered care for all members of the Greater Dayton community. Through a multimodal workshop, participants will gain insights and lessons from the Greater Dayton Advance Care Planning Initiative's: 1) early development and ability to leverage community partnerships and key institutional leaders to launch Decide to be Heard; 2) current operations and behind-the-scenes maneuvering to promote systems' change in the Dayton region; and 3) preparations for sustainability and shared ownership among a diverse, multi-stakeholder partnership of organizations and community leaders. Participants will develop core components of a community-based plan that reflects their community's advance care planning key players, potential funding mechanisms and operational strategies, and maximizes existing collaborative partnerships to apply lessons learned and share insights with fellow participants during the workshop.

During this workshop, attendees will participate in three separate small and large group activities to complete a roadmap-style worksheet to help them develop core components of an action plan to foster conversation and develop a community-focused convener model.

1. The first activity will focus on identifying likely sponsor organizations within their own community as well as potential champions that could work collaboratively to bring together key institutional partners to share the work of a convener model.
2. The second activity will focus on identifying and brainstorming potential solutions to organizational challenges that occur within many organizations attempting to implement the Respecting Choices model of advance care planning.
3. The third activity will help attendees to map out potential options of shared ownership for a community convener model ---including program management, training and development, community outreach, public awareness, and fund development for sustainability and growth.

After each activity each group will report out recommendations and strategies to share with the larger group.

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4. To Bill or Not to Bill, That is the Question?! Using ACP Codes in Your Daily Practice

Phil Rodgers, MD FAAHPM, Associate Professor, Family Medicine and Internal Medicine, University of Michigan; Sandra Schellinger, MSN, RN, NP-C, Senior Faculty and Consultant, Respecting Choices

Panelists: Kellie Durgan, BSN, RN, Manager, Advance Care Planning, Providence Health Care; Lynda Tang, DO, Vancouver Clinic, Department of Palliative Medicine; Kathryn Pence, PA-C, Vancouver Clinic, Internal Medicine; Cindy Adams, BSN, RN, CHPN, Regional Advance Care Planning Coordinator, Baptist Health

Outcomes:

1. Describe a general overview of CMS ACP billing codes and updates since 2016. (General ACP billing overview)
2. List the details of the ACP billing codes and what is and is not allowed by CMS or other payers in different locations and patient situations. (Case Studies)
3. Define strategies to create a system to report and bill for ACP services in an organization.

Abstract Description:

While the value of assisting patients or individuals to effectively plan for future health care decisions has become increasingly clear, one of the biggest barriers to providing advance care

planning has been the cost of providing this service. Since January 2016, it is possible for providers to report ACP CPT codes and bill for ACP services. Although most recent CMS data shows an uptake of reporting ACP CPT codes over the last two years there are still questions for most organizations on when, where, how and who should be billing for ACP services. In this workshop the speakers will address some of the most common questions organization face when setting a system to report and bill for ACP services. Strategies for how billing codes might be put into practice will be explored through case studies. Individual knowledge will be tested using an interactive polling system. The workshop will conclude with a discussion with a panel of organizations who are currently reporting ACP CPT codes.

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5. Leadership Strategies that Support Person-Centered Care (two-part workshop)

Adopting and sustaining a culture of person-centered care is a challenge with constant barrage of financial, political, and societal issues organizations are facing today. This two-part workshop will engage attendees in conversations about what it takes to build and sustain a culture of person-centered decision-making. Speakers will describe the concept of an interprofessional model that supports person-centered decision making, its power to transform the healthcare culture, and the leadership best-practices required to deliver on the promise of person-centered care. Small and large group discussion will identify person-centered metrics, measures of cultural transformation, and best-practices in person-centered care.

a. Respecting Choices: The Evolution into a System for Person-Centered Decision Making That Transforms Healthcare

Carole Montgomery, MD, FHM, MHSA, Director, Physician Development and Program Improvement, Respecting Choices

Outcomes:

1. Examine person-centered decision making as one attribute of person-centered care
2. Describe how advance care planning and shared decision making together complete an interprofessional model for person-centered decision making
3. Describe how implementing person-centered decision-making programs change healthcare culture
4. Identify possible metrics to measure a culture shift in person-centered care

Abstract Description:

The longstanding goal of the Respecting Choices programs has been "to know and honor individuals' preferences and decisions." This presentation will describe how Advance Care Planning and Shared Decision Making in Serious Illness integrate with each other, creating an interprofessional approach that supports individuals through their decision-making process by using consistent language, strategies and processes across sites of care and over time. The presenter will examine how with implementation of person-centered decision-making programs, organizations will observe a culture change demonstrated by a set of acceptable behaviors and expected interactions with individuals going through a decision-making process. Small and large group discussion will assist attendees to identify a set of person-centered care metrics that can measure this transformational change, "ensuring that patient values guide all clinical decisions."

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b. Building the Systems and Culture that Delivers Person-Centered Care

Jeff Thompson, MD, Executive Advisor, CEO Emeritus, Gundersen Health System

Outcomes:

1. Describe the leadership tools to make the whole system responsive to the patients and their families.
2. Identify strategies that build a 'system's map' of person-centered strengths while addressing current organizational gaps and weaknesses.
3. List two or more leadership best practices that can sustain a culture of person-centered care in an organization.

Abstract Description:

To maximize the impact of a person driven advanced care plan, you need to support it with a disciplined system of caring. The cornerstone of that system needs to be an outward facing culture that regards the patient's wishes as paramount. This session will examine how to leverage the organizational mission and plan to set a path that values a person-centered culture and environment that supports the care team and those they serve. Presenters will share tools and a plan that will Inspire the majority and manage the remainder to drive a self-examining, constantly improving system that delivers on the promise of person-centered decision-making across all parts of the health system and community. Participants will engage in small and large group discussion to collect person-centered care best practices.

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6. An Almost Murder Mystery – A Theatrical Display of Family Dynamics When Proper Advance Care Planning is Absent

Lynn R. MacKenzie, Instructor, Executive Director, Light the Legacy

Outcomes:

1. Describe how the use of theatre can be used as a community engagement strategy to promote person-centered advance care planning conversations with individuals, family members, and employees of an organization.
2. Apply collaboration principles that promote community organizations to partner in delivering the messages of person-centered advance care planning.

Abstract Description:

Even though an individual may think they have prepared appropriately, uninformed family members and family dynamics change what may happen in a crisis As a component of a community engagement strategy in Central Minnesota to promote advance care planning (ACP), a play, *An Almost Murder Mystery* was performed in partnership with The Convenings, the Bruce Kramer Collaboration and CentraCare Health. The play was performed by local GREAT Theatres actors performed at several theaters in Central Minnesota, bringing in over 500 community members

This workshop will include and overview of The Convenings and a play, "An Almost Murder Mystery" (20 minute DVD), written to creatively engage the community and families when the "what if's" in life happen, followed by small and large group activities.

You will be invited to watch this movie which invites you into the home of Agnes Rogers, where her four adult-children and son-in-law gather following a visit to Agnes in the Intensive Care Unit of the hospital. Agnes was in a sudden and tragic car accident that left her with a severe traumatic brain injury. She cannot speak for herself. It is questionable if she will even survive and in what condition.

1. This small group activity reflects on personal experiences in the event loved ones are critically injured or ill and are unable to make decisions and how can affect family dynamics. Each family member is different and holds their own unique values on life and death.

Families can be torn apart during such trying times or they can pull together as a family unit.

2. This small group activity explores different strategies to apply the use of theatre to reach out and engage community members or employees within your organization.
3. Each small group activity will be followed by a large group debrief of key themes related to person-centered ACP conversations and decision-making.

Plenary Session

Advance Care Planning: Takeaways from Hamilton

Amy Vandenbroucke, JD, Executive Director, National POLST Paradigm

Outcomes:

1. Describe the challenges of supporting individual autonomy using state advance care planning documents.
2. Identify at least three strategies to help individuals navigate multi-state advance care planning.
3. Understand the legislative changes that need to occur to support individuals wanting effective and legal advance care plans.

Abstract Description:

Advance care planning (ACP) is unnecessarily difficult considering simple goal of providing individuals a way to communicate treatment wishes and identify a surrogate to speak on their behalf when they lack capacity to participate themselves. Individuals should be encouraged to complete ACP to ensure treatments and care plans reflect person-centered wishes and outcomes and healthcare systems need to ensure those wishes are honored. Unfortunately, it is usually during an emergency that people discover an advance care planning document is invalid or "not quite right" or healthcare systems and professionals do not know how to interpret or use the available document, all which may result in unwanted or unnecessary treatments.

The variation among state laws and documents create challenges to accessing and using ACP tools appropriately. The legal system is a challenging labyrinth of forms, legalese, and inconsistent state laws and regulations. It is confusing to know what forms to use and how well those forms support individuals traveling and/or who live in one state but receive healthcare in another. This confusion, that exists among health care professionals and the public alike, creates an unnecessary barrier to having quality advance care planning conversations and completing the right documents.

Using advance directives and the POLST Paradigm as examples, this presentation will discuss how we can support patients traveling across state lines or who live on a state border complete appropriate advance care planning documents. It will also share what changes need to be made to make the current system easier for individuals and systems to complete a person-centered ACP conversation and meet the legal requirements for the appropriate advance care planning documents.

Concurrent Sessions 2

1. Customization of ACP in a Culturally Diverse, Faith-Based Community

Implementation Strategies to Engage a Diverse Patient Population in Next Steps Advance Care Planning

Christine Swift, RN, MSN, Manager, Community Medical Centers

Outcomes:

1. Describe the concepts and implementation challenges of working with people within the culture of poverty.
2. List the person-centered ACP implementation strategies that can be helpful in connecting with different cultural groups.

Abstract Description:

Community Regional Medical Center (CRMC) is a 722 bed safety-net facility that is nestled in downtown Fresno. Fresno is the most impoverished county in California and the second-most impoverished area in the U.S. (Associate Press, 2012). Our patients are also culturally and linguistically diverse, with 30% of our clinic population Spanish speaking and 66% identified as Hispanic. 73% of patient visits to our ambulatory clinics we covered by Medi-Cal (Medicaid) compared to a 43% rate of Medi-Cal overall in our region (Community Medical Centers, 2017).

Analysis of our first wave of implementation revealed a gap in our ability to engage our patients to participate in Advance Care Planning (ACP). This presentation will describe several implementation changes, patient education and engagement materials, and integration of specific workflows necessary to support the person-centered ACP needs and meet the socio-economic, cultural and linguistic realities of our patients. So far, we have engaged patient to participate and complete in Next Steps conversations at a higher rate than in the first wave of implementation.

The use of a patient education and engagement video has been particularly effective in engaging patients and their agents to participate in Next Steps ACP. This bi-lingual video was made to describe basic ACP principles and to motivate and engage patients using culturally relevant patient stories.

Changes to our communication workflows and how we invited patients with no healthcare agent were also important in improving engagement of our diverse population. By learning and addressing our patients' cultural needs, we were able to increase engagement and efficiency of our ACP program.

Hope, Miracles, Pragmatism, and Death: An Interfaith, Community-Based Advance Care Planning Initiative Comes to Life

Carol F Robinson, DNP, MS, BSN, RN, CHPN, Community Coordinator, Making Choices Michigan

Objectives:

1. Self-report of intent to apply interfaith dialogue techniques when engaging in PCC ACP conversations.
2. Identify strategies to promote embedded ACP education and facilitation conversations in interfaith/belief group settings.

Abstract Description:

Advance care planning (ACP) conversations in well adults can decrease stress for the individual and the patient advocate. Conversations should include a person's spiritual values, and how those beliefs could influence end-of-life treatment choices.

This presentation will describe the experience of a Midwestern town where a community-based ACP organization partnered with a university-based interfaith dialogue initiative to increase ACP education and completion of advance directive (AD) documents. Five interfaith groups agreed to embed ACP education and facilitators within their groups. They also agreed to learn interfaith dialogue techniques to improve their facilitation skills.

Combined, the interfaith groups provided ACP education to over 540 people, with 135 people requesting an ACP conversation. Sixty-one percent followed-through within the 6-month time frame. Further, 53 (64%) individuals completed an Advance Directive (AD), and 75% of those individuals registered their AD on the statewide Health Information Exchange. The completed directives counted for 62% of all ADs completed in the 6-month timeframe of the community-based organization.

The interfaith facilitators became adept at discussing the differences between their faith/beliefs, and how to specialize their conversation to better reflect a person's preferences on the AD form. In some groups, additional doctrinal tools were added to their ACP packets to further clarify values/beliefs.

Finally, spiritual leaders found that the conversation provided useful information to be used at the time of death and subsequent planning for memorial services. Conversation participants took comfort in sharing memorial preferences of their loved one with the spiritual leader. Interfaith initiatives are a useful tool for communitywide ACP uptake.

2. Leadership Strategies to Promote Person-Centered Care

Thriving Through Leadership Transitions

Stephanie Anderson, DNP, Deputy Executive Director, Respecting Choices; Mary Catlin, MS, CCLS, Senior Director, Honoring Choices® Pacific Northwest

Outcomes:

1. List three effective leadership orientation strategies that support advance care planning and shared decision-making.
2. Discuss approaches to maintain leadership engagement and support.
3. Identify impact of leadership transitions during each of three phases: implementation, dissemination, and sustainability.

Abstract Description:

At the core of all successful person-centered care programs are committed and engaged leaders. Programs that support advance care planning and shared decision making depend on their guidance and support to reach the goal of knowing and honoring individual preferences and decisions. This session will cover strategies to orient leaders to the programs, engage leaders across the life of the programs, and respond effectively when there are changes in leadership.

The presenters will discuss the impact of leadership transitions early in an implementation as well as during dissemination and/or sustaining the programs. Participants will learn orientation and maintaining leadership engagement strategies, and most profoundly, hear lessons learned from real life experience.

Creating Sustainable ACP Leadership Engagement Through Experience

Nikketta (Nicky) M. Lewis, LMSW, Advance Care Planning Coordinator, Mercy Health Saint Mary's

Outcomes:

1. Describe targeted leadership engagement strategies to increase support for ACP implementation.
2. Create an intervention targeting senior and clinical leadership for engagement in facilitated ACP conversations.
3. Identify two methods to promote long-term sustainability for ACP facilitated conversations.

Abstract Description:

A critical step in developing a sustainable ACP program is strong Leadership Engagement (Briggs & Hammes, 2011). Central to the integration of person-centered care (PCC) within acute and primary care settings, advance care planning (ACP) is about hearing individual preferences and acknowledging personal goals, values, and beliefs (Brimmel-Smith, et al., 2016). We decided the best way to improve person-centered outcomes was to help leaders understand why it is necessary to fundamentally change how we engage our patients and community around ACP.

This presentation will describe how we engaged our leadership colleagues as a target population for our Respecting Choices® implementation; including senior leadership, even the Regional Health Ministry President.

Our team identified 33 senior leaders from acute and ambulatory care settings. The hospital was able to offer ACP conversations to 94% of identified leaders. From this group of leaders, 67% participated in facilitated conversations and 70% of completed conversations included a patient advocate.

We found that leaders who have personally experienced the value of ACP conversation are better able to communicate its importance to colleagues and patients. PCC can only truly be realized through our shared humanity of understanding what our patients experience. Targeting senior leaders and engaging them in personal facilitated conversations has eased the spread of ACP to our colleagues and community. Now ACP First Steps® programs are offered to our community, inpatient units, and several of the ambulatory care offices. Planning is underway to expand ACP to other regional ministries.

3. Organizational and System Strategies Using Technology

Leveraging Technology to Scale High-Quality Advance Care Planning

Ryan Van Wert, MD, Co-Founder and Chief Medical Officer, Vynca

Outcomes:

1. Describe 1-2 technology strategies can unify and streamline advance care planning programs.
2. Create a technology business case for developing an electronic platform that supports person-centered advance care planning documentation at your organization.

Abstract Description:

Person-centered Advance care planning (ACP) can be difficult to operationalize. Studies have shown that eighty-seven percent of the time care plans are not available at the scene of an emergency, and only 31% of emergency providers express confidence in the ability to locate ACP

documents in the EHR. This leads to unnecessary hospital admissions, ICU utilization, and ultimately low patient and family satisfaction.

This presentation will describe how the use of multi-faceted ACP technology can be developed to engage the patient and family members in ACP conversations, to electronically document care plans and medical orders, and to make these documents electronically available to providers throughout all care settings. Key technology components will be described that are needed to drive successful patient-centered ACP. Outcomes, in particular how ACP improves the patient and family experience. Attendees will receive a template to create a business case to help design and implement an ACP program at your organization.

Developing a Collaborative Relationship with Your EMR Team to Optimize Functionality for Documentation, Storage and Retrieval

Chris L. Brinneman, MSW, LCSW, Manager ACP, Parkview Health; Amy L Spallinger, MSW, LCSW, First Steps ACP Organization Faculty; Kathy Saalfrank, RN, Epic Build Analyst III, Parkview

Outcomes:

1. Describe two strategies to overcome language differences between an ACP team and the EMR team.
2. List essential elements of a person-centered ACP EMR documentation project plan.
3. Explain two approaches that can support the development of collaborative relationships between clinical and EMR teams.

Abstract Description:

From January 2017 to March 2018, the Advance Care Planning (ACP) department at Parkview Health worked to create documentation, storage and retrieval foundations and functionality in the electronic medical record (EMR). One of the advantages of an EMR over a paper chart is easy accessibility from anywhere at any given time (Anderson, 2007). This presentation will describe the evolving collaborative relationship that occurred between the ACP department and EMR team during the optimization of electronic person-centered ACP documentation. Based on our experiences, we will review the steps taken to pro-actively identify the current and future needs for both “sides” and avoiding possible barriers. We identified three key areas: 1) development of a project management scope document which identifies the purpose, technical considerations, deliverables, goals, objectives, and timelines, 2) Identify and capitalize on each other’s expertise and what each department needs to learn to speak the same languages to “level the playing field.”, and lastly, 3) to overcome silo mentality, facilitate intentional relationship building through scheduled weekly meetings and recognition of individual and team successes.

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4. Innovations in Delivering Last Steps ACP

Last Steps Facilitators in the Hospital Setting: A Collaborative Test of Change

Denise Nicholson, BSN, RN, Nursing System Specialist, Gundersen Health System

Outcomes:

1. Describe one strategy used to identify individuals through the EHR who are appropriate for POLST.

2. List 3 key components that are necessary to create a successful POLST service in the hospital setting.

Abstract Description:

As individuals near the end of life, they may be offered the opportunity to express their future treatment preferences through completion of a POLST form, which translates those preferences into medical orders that can be followed across care settings. Ideally, patient preferences are elicited through thoughtful conversation between the patient and/or surrogate decision maker and a clinician. However, clinicians often lack sufficient time or the skills necessary to lead the conversation.

To address these barriers, this presentation will share our experience of implementing a process that partners clinicians with Respecting Choices Last Steps® facilitators who have been trained to conduct meaningful conversations and complete medical orders reflective of patient goals and values. Clinician partners are available as needed to answer questions about the patient's condition and prognosis. Our target group was older adults with hip fracture. Patient eligibility criteria for POLST and a best practice alert (BPA) were built into the electronic health record (EHR). When clinicians access the EHR of patients who meet the criteria, a BPA prompts them to consider scheduling the Last Steps service. Early identification of appropriate patients, ease of communication through the EHR, and clinician buy-in were key to smooth implementation of the project, the impact of which appears promising. In fact, clinicians introduced to Last Steps through their work with the targeted patient group have begun to refer patients other than those with hip fracture to the Last Steps service. Our next step is to assess the impact of the project on the number and quality of POLST forms completed.

Systematic Advance Care Planning and Potentially Avoidable Hospitalizations of Nursing Home Residents

Susan E. Hickman, PhD, Professor, Indiana University School of Nursing; Mary Ersek, PhD, RN, Professor, Pennsylvania State University School of Nursing; Greg Sacks, MD, Professor, Indiana University School of Medicine

Outcomes:

1. Describe strategies necessary to systematically implement person-centered advance care planning in nursing homes using the Respecting Choices Last Steps ACP program
2. Explain the associations between who is offered Last Steps ACP conversations compared to resident characteristics and hospitalization rates.
3. Identify challenges inherent in analyzing the outcomes of a multi-component intervention.

Abstract Description:

Prior research suggests associations between nursing home (NH) residents' preferences for comfort-focused care and lower rates of hospitalization. This presentation will describe study results that compare hospitalization rates among residents following intensive efforts to systematically offer advance care planning (ACP). A sample of 1,468 NH residents were enrolled in a multi-component demonstration project designed to reduce potentially avoidable hospitalizations between January 2015 – June 2016. Residents participated in person-centered Last Steps ACP conversations facilitated by project nurses certified in Respecting Choices Last Steps facilitated ACP. Hospitalizations were tracked using Minimum Data Set 3.0 data and judged as avoidable or unavoidable by project nurses.

Comparisons were made between residents based on ACP status: 1) ACP indicting comfort care/DNH (n = 497, 33%); 2) ACP with other preferences (e.g., code status only: n = 771, 52%); and

3) no ACP (n= 218, 15%). Compared to the comfort care/DNH group, the overall hospitalization rate was 1.47 times higher for patients having other ACP preferences (p=.005) and almost 2 times higher for those with no ACP (p=.0003). Compared to the comfort care/DNH group, avoidable hospitalizations were 2.48 times higher than for those with no ACP (p=.0005). However, when adjusted for covariates including gender, age, hospice, functional status, and cognition, there were no differences between the three groups.

In this large, non-randomized study, the association between lower hospitalization rates and ACP status were no longer significant once fully adjusted for resident characteristics. Isolating the effects of ACP may be challenging due to study design (multi-modal intervention, non-randomized) and the nature of the population.

5. Organizational and System Strategies of Small- and Large-Scale Implementation

Putting Pieces Together – A Multidisciplinary Team Implementing Respecting Choices in a Quaternary Health System Demonstrating Real Change and Potential Sustainability

Iris F. Boettcher, MD, MCD, Division Chief Geriatrics, Home-Based Primary Care and Home and Community Services, Spectrum Health

Outcomes:

1. Identify three strategies used to implement a small test of change of the Respecting Choices approach to person-centered care within a large health system
2. Demonstrate how a large health system used the electronic healthcare record as a tool to assist with implementation of Respecting Choices person-centered care approach

Abstract Description:

The zenith of implementing the Respecting Choices systems approach to advance care planning (ACP) is to provide person-centered care for each individual that honors current and future healthcare preferences. It is essential to understand that challenges exist for a quaternary health system to honor each individual's preferences. Challenges include but are not limited to; (1) assuring conversations are initiated and completed (2) broken or insufficient communication regarding healthcare preferences as result of conversations, and (3) difficulty in healthcare providers accessing information on preferences in real-time. This presentation will demonstrate how a strategy of using a multidisciplinary ambulatory care team as early adopters in a large quaternary health system supported identification and experimentation with solutions to these challenges. The presenter will discuss the importance of the team approach to honoring patient preferences, in addition to the role of the ACP facilitator and provider in facilitating shared decision making (SDM) conversations. The use of monitoring this small test of change and results of experiments resulting in development of standard work utilizing the electronic health record (EHR) as a tool to support ACP and SDM will be shared.

There's No Place Like Home – For ACP Conversations. ACP Facilitators Do Make House Calls

Dianne K. Schultz, MSN, RN, Director of Operations, Unity Point Ambulatory Division, Care at Home Clinic/Hospital to Home Services

Outcomes:

1. Identify and understand the importance the role of key stakeholder's engagement and collaboration in a multi-site person-centered ACP implementation plan.
2. Describe home based specific test of change strategies when implementing person-centered ACP across multiple sites of care.

Abstract Description:

Knowing a patient's goals, values, and preferences is extremely helpful to both loved ones and healthcare professionals to support person-centered advance care planning (ACP). Prior to 2015, the Patient Self Determination Act provided the Cedar Rapids Region the standard approach to promoting an informed decision-making process for future medical care. This presentation will describe the UnityPoint Health (UPH) system experience of how they went about developing and implementing a comprehensive, coordinated approach to person-centered advance care planning (ACP) in a home-based care setting.

Home Care patients are often frequent utilizers of health services and in need of additional support. In 2015, UnityPoint at Home was selected as one of the six, first-wave sites in the Cedar Rapids region to be trained in First Steps (FS) Advance Care Planning (ACP). Successful outcomes of increased patient participation in facilitated conversations and an increased in the percentage of completed AD in the medical record supported the justification of spreading a First Steps strategy across nine Home Care regions in three states within the UPH system. Practical implementation tips of embedding the ACP process with current work practices of the Home Care social workers will be shared. Through this innovative work, advance care planning has become a key component to the population health strategy and is aligned to value based purchasing measures and our promise to know and honor patient wishes.

Plenary Session

The Power of the Collaborative: The Honoring Choices® Pacific Northwest Convener Model

Jessica B. Martinson, MS, Director, Clinical Education and Professional Development, Washington State Medical Association

Outcomes:

1. Describe the leadership strategies used to convene health care organizations and community groups across the region to prioritize advance care planning as a shared call to action and ultimately deliver measurable improvements.
2. Discuss the risks and benefits, as well as strategies used to launch 49 teams from 27 health care organizations within a two-year period; including recruiting, engaging, supporting, overcoming barriers, and celebrating successes.

Abstract Description:

Honoring Choices Pacific Northwest is a jointly sponsored initiative of the Washington State Hospital Association and Washington State Medical Association. Through collaborative partnerships, Honoring Choices PNW serves as the convener for a region-wide advance care planning program implementation of the Respecting Choices® First Steps® ACP program. In addition, Honoring Choices PNW is launching programs for community engagement, physician and

advance practitioner professional development, advocacy and a central repository for advance directives and POLST forms. This plenary session will outline leadership strategies, risks and benefits, lessons learned, and measurable outcomes.