

**Respecting Choices<sup>®</sup>**  
PERSON-CENTERED CARE

**National Share the Experience 2018**

**Improving Person-Centered Outcomes Through Collaboration**

**October 23–26, 2018  
Bloomington, Minnesota**

**PROVIDENCE**  
Medical Group

**PROVIDENCE**  
Medical Group

**Supporting patients through the continuum of care**

**Kellie Durgan RN BSN**  
Manager, Advance Care Planning  
Providence Health Care, eastern Washington  
October, 2018

## Objectives

- Strategies to carry patient-centered goals from primary care to acute care and back again
- Identify partners committed to whole person care
- Using shared medical record to keep the patient's story at the center of care

## Silos in health care



## Inpatient barriers

- “These conversations belong in primary care”
- Default Full Code – conversations with any depth are rare
- Rotating hospitalists and intensivists allow “anonymity” to perpetuate

## Primary Care Barriers

- “No one in the hospital reads my notes”
- We have at least 12 different metrics we are required to address – I don’t have time for full ACP conversations
- Execution barriers included non-related witnesses or notaries for legal documents – what are your state mandated barriers?

## Moving upstream



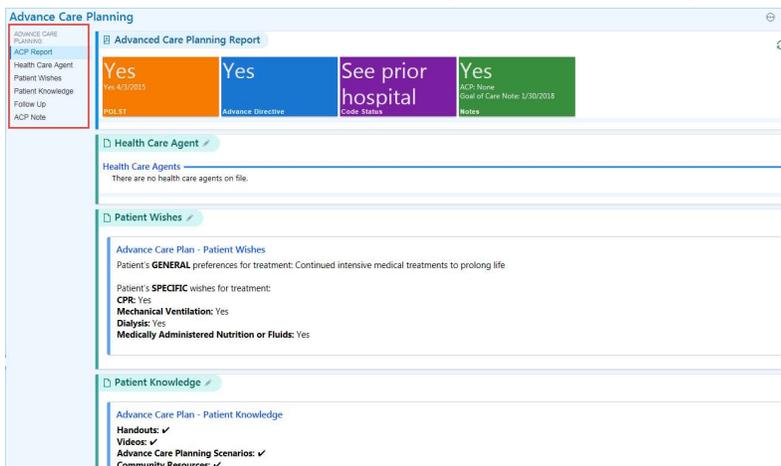
## Bringing people together

- RN Care Navigators willing to identify ACP gaps to patients as part of chronic care management and DC from hosp.
- Facilitators in PCP offices willing to engage and encourage patients to talk about goals and values

## Adding Home Health

- Expanding primary palliative care skills of home nursing team with focus on assessment and interventions over longer period
- Easy conversation starters suggested
- How to close the loop and create documents with patient values and goals expressed

## One Epic to carry the story



The screenshot shows the 'Advance Care Planning' section in an Epic EMR. It features a navigation menu on the left with options: ADVANCE CARE PLANNING, ACP Report, Health Care Agent, Patient Wishes, Patient Knowledge, Follow Up, and ACP Note. The main content area includes:

- Advanced Care Planning Report**: A summary bar with four colored boxes: 'Yes' (orange, POLST, Yes: 4/2/2013), 'Yes' (blue, Advance Directive), 'See prior hospital' (purple, Code Status), and 'Yes' (green, ACP Note, Goal of Care Note: 1/30/2018, Notes).
- Health Care Agent**: A section with a dropdown arrow and the text 'Health Care Agents - There are no health care agents on file.'
- Patient Wishes**: A section with a dropdown arrow and a text box containing: 'Advance Care Plan - Patient Wishes', 'Patient's GENERAL preferences for treatment: Continued intensive medical treatments to prolong life', and 'Patient's SPECIFIC wishes for treatment: CPR: Yes, Mechanical Ventilation: Yes, Dialysis: Yes, Medically Administered Nutrition or Fluids: Yes'.
- Patient Knowledge**: A section with a dropdown arrow and a text box containing: 'Advance Care Plan - Patient Knowledge', 'Handouts: ✓', 'Videos: ✓', 'Advance Care Planning Scenarios: ✓', and 'Community Resources: ✓'.

## Role of leadership

- Culture of concordance established
- Whole person care is a stated, stand-alone strategic goal for our system
- FT ACP Coordinator, support for facilitator training and conversation time
- Policy creation – employed notaries, volunteers as witnesses

## New challenges and plans...

- Adding ACP as a routine to advance heart failure clinic (using Advance Steps conversations with RN facilitator)
- Considering ACP as an intervention to prevent 30 day readmission for HF and COPD – must find a “soft place to land” for those who don’t want to return to the hospital.

## Strategic Messaging



## It takes a village (of people 😊)

