PERSON-CENTERED CARE: WHAT IS THE VALUE PROPOSITION OF THE NEXT STEPS™ ADVANCE CARE PLANNING CONVERSATIONS?

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

Sandra Schellinger, MSN, RN, NP-C Senior Faculty Consultant, Respecting Choices
Learning Outcomes

• Describe the gap in advance care planning when individuals only complete a First Steps and/or Advanced Steps ACP conversation
• Describe the value proposition for organizations who provide Next Steps ACP conversations compared to First Steps ACP and/or Advanced Steps conversations alone.
• Identify at least one metric for each quadrant of the quadruple aim that demonstrates the unique value of NS ACP conversations.

Six Domains of Quality Healthcare

Safe  Effective
Patient-centered  Timely
Efficient  Equitable

(Crossing the Quality Chasm: A New Health System for the 21st Century, IOM, 2001 http://www.nationalacademies.org)
Honoring Individual Preferences = Quality

- Person-Centered, Family Oriented Care
- Clinician-Patient Communication
- Advance Care Planning
- Professional Development
- Policies and Systems
- Public Engagement

(IOM, 2014 http://www.nationalacademies.org)

Knowing and Honoring Preferences and Decisions

“Care that is respectful of and responsive to individual patient preferences, needs, and values, ensuring that patient values guide all clinical decisions”

(IOM, 2001)
The desired outcome of Person-Centered Decision Making (PCDM) is to know and honor individuals’ well-informed preferences and decisions by...

- Creating an effective process to plan for future decisions
- Making plans available to treating health professionals
- Assuring plans are incorporated into current medical decisions

Stages of Person-Centered Decision Making

**First Steps® ACP**
- **Target Population:** Adults who have not started or engaged in a planning process

**Next Steps™ ACP**
- **Target Population:** Individuals engaged in active disease management experiencing complications

**Advanced Steps ACP**
- **Target Population:** Individuals in their last few years of life

**Shared Decision Making in Serious Illness™**
- **Target Population:** Individuals with serious illness making a current healthcare decision

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What approach to person-centered advance care planning conversations does your organization use for individuals living with serious illness?

- First Steps ACP Conversations
- Next Steps ACP Conversations
  - Advanced Steps Conversations
  - Shared Decision Making in Serious Illness
- Other
- No Specific Approach at this time
THE NEXT STEPS ACP CONVERSATION: OVERVIEW

Key Features
(Triggs, 2004)

Target Population

Next Steps
- Serious illness with complications
- Functional decline
- Co-morbidities
- Frequent hospital or ER visits
Next Steps ACP Conversation: Key Features

• 1.5-hour conversation with individual and healthcare agent in outpatient setting
• Scheduled when individual is medically stable
• Assumes most intend to continue with plan of care to manage their serious illness

Next Steps ACP Conversation: Key Features

• Provides context for helping individuals identify:
  • Goals of care for future disease-specific complications
  • “Unacceptable outcomes” that would change goals of care
Next Steps ACP Conversation: Key Features

- Delivered by qualified Facilitators using a structured conversation and person-centered communication techniques to promote shared decision making.

Preparation for situations of serious illness decision-making

Statement of Treatment Preferences Form

- Purpose:
  - Discuss two types of decisions
    - Situation-based
    - Life-sustaining treatment
  - Assist in preparing agent for future decision-making role
SoTP Situations

- Situations common to all SoTPs
- High survival with cognitive disability
- High survival with functional disability
- High burden and low survival

Respecting Choices

- Stories of person-centered care have always been at the heart of our work.

  - Rock Center Video
  - The conversations are not scripted.
  - The facilitated ACP conversation is Next Steps.
Person-Centered Decision Making: Impacts the Quadruple Aim

Adapted from: www.ihi.org/Engage/Initiatives/TripleAim
Better Population Health

- Increases prevalence and integrates ACP throughout the community
- Positively impacts health of surviving loved ones (decreased stress, anxiety, and depression)
- No evidence of negative impact on life-expectancy across population

Better Care: Person-Centered

- Assists in providing care and treatment that is consistent with individual goals and values
- Results in high individual and family satisfaction
Better Care: Equitable, Accessible, and Reliable

- Increases prevalence of planning in racially, ethnically, and culturally diverse communities
- Increases hospice use at end-of-life
- Promotes timely and appropriate referrals for other needed services (care coordination)

Lower Costs

When an individual’s goals and values are understood and honored, ACP:

- Reduces unwanted care, treatment, and hospitalizations
- Reduces utilization and cost of care in last two years of life
- Reduces in-hospital deaths
Provider Vitality

• Decreased moral distress through increased understanding of individual’s goals, values, and preferences
• Satisfying ACP conversations
• Improved meaningful interprofessional team communication

The Value Proposition of Next Steps Advance Care Planning Conversations
Expected Person-Centered Decision-Making
Long-Term Outcomes

• Increase in % of plans available at time of death
• Reduce # of hospital deaths
• Increase # of hospice admissions
• Increase hospice median length of stay

• Increase transfer of written plan to appropriate medical orders (i.e., evidence that plan was followed)
• Increase family members’ reports of patient’s medical plan consistent with written plan

What one word best describes the unique value of the Next Steps ACP Conversation?
• Carlos Sanchez is a 58-year-old male who has been living with Type 1 Diabetes since his late teens.
• His symptoms from peripheral vascular disease prevent him from being able to walk for long distances and exercising.
• Over the last year-and-a-half he has had progressive renal insufficiency.

First Steps ACP Conversation

Target Population

<table>
<thead>
<tr>
<th>First Steps (FS) ACP</th>
<th>Next Steps (NS) ACP</th>
<th>Advanced Steps (AS) ACP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults who have not started or engaged in a planning process</td>
<td>Individuals engaged in active disease management AND experience complications</td>
<td>Individuals in their last few years of life</td>
</tr>
</tbody>
</table>
## Purpose of Conversation

<table>
<thead>
<tr>
<th>First Steps (FS) ACP</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Select and prepare a healthcare agent</td>
<td>Understand future complications based on illness trajectory</td>
<td>Define preferences in context of life-limiting illness and “living well”</td>
</tr>
<tr>
<td>Discuss goals for care for a severe, permanent brain injury</td>
<td>Identify goals if complications result in “unacceptable outcomes”</td>
<td>Integrate individuals’ preferences into physician orders</td>
</tr>
<tr>
<td>Identify personal, cultural, spiritual beliefs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Benefits to the Individual

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</tr>
</thead>
</table>
| Introduces ACP as a routine part of healthcare; normalizes the conversation | Engages/empowers participation in current decision making, impacting:  
- Care coordination and referrals  
- Specific treatment decisions  
Prepares for future healthcare decisions:  
- Continue/withhold/withdraw treatment if ‘unacceptable outcomes’  
Other decision-making gaps not addressed by FS or AS | Specific life-sustaining treatment decisions made in advance; directing future care through physician orders |

ALL: Prepare agent if individual becomes unable to make own decisions
### Triggers for conversation (examples)

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<tbody>
<tr>
<td>- Age (e.g. &gt;55 years)</td>
<td>Active care management with:</td>
<td>- Terminal illness diagnosed</td>
</tr>
<tr>
<td>- Annual wellness</td>
<td>- Complications</td>
<td>- Long-term care admission for frail elders</td>
</tr>
<tr>
<td>- Community initiative</td>
<td>- Co-morbidities</td>
<td>- Individual expressions of changing values and goals</td>
</tr>
<tr>
<td>- New admissions into care management program</td>
<td>- Increased clinical encounters</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Functional decline</td>
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### Decisions Made During ACP Conversation

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<tbody>
<tr>
<td>- Health care agent(s)</td>
<td>- Prepare for disease-specific future decisions (e.g. dialysis, additional</td>
<td>When treatment should not be started, or when it should be withdrawn:</td>
</tr>
<tr>
<td>- Authority of agent</td>
<td>cancer treatment, LVAD or implantable defibrillator removal)</td>
<td>1. CPR</td>
</tr>
<tr>
<td>- Goals for continuing LST if severe, permanent brain injury</td>
<td>- Threshold for withdrawing treatment if complications result in “unacceptable</td>
<td>2. Description of type of care desired:</td>
</tr>
<tr>
<td>- Optional: may discuss CPR</td>
<td>outcomes”</td>
<td>(Comfort-focused care/ Selective treatment (limited interventions)</td>
</tr>
<tr>
<td></td>
<td>- Preferences for CPR, airway mgmt., and artificial nutrition</td>
<td>Or Full treatment +/- trial of interventions</td>
</tr>
</tbody>
</table>
<pre><code>                                                                                 |                                                                                     | 3. Artificial Nutrition                                                              |
</code></pre>
### Future Decisions Supported by Prior ACP

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<tr>
<td>In catastrophic event</td>
<td>All along disease trajectory (not just at death) and at death <strong>Need measures Upstream of ‘decedent data’</strong></td>
<td>At time of death (or shortly before that) <strong>Impact measurable in decedent data</strong></td>
</tr>
</tbody>
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### What quadruple aim domain(s) are you measuring for individuals living with serious illness? (select all that apply)

- Better Health: Physical, mental, and social well-being of individuals and family members.
- Better Care: Individuals and family member’s experience including quality, equitable, accessibility, and satisfaction.
- Lower Costs: Cost of care when treatments align with goals (utilization/cost).
- Provider Vitality: Clinician/Staff well being.
- Other measures not listed.
Person-Centered Decision Making: 
Next Step ACP Conversation Impacts the Quadruple Aim

Adapted from: www.ihi.org/Engage/Initiatives/TripleAim

Better Health

What outcome measure(s) demonstrate better health of individuals and families living with a serious medical condition(s)? (Physical, mental, and social well-being)
What outcome measure(s) demonstrate delivery of person-centered care for individuals and families living with a serious medical condition(s)?

Better Care: Person-Centered

What outcome measure(s) demonstrate that individuals and families living with a serious medical condition(s) receive equitable, accessible, and reliable care?

Better Care: Equitable, Accessible, and Reliable
What outcome measures demonstrate the impact on cost of care when individuals living with a serious medical condition(s) receive care that aligns with their goals, values, and preferences?

**Lower Costs**

What outcome measures demonstrate improvement in the clinician’s experience when delivering care for individuals living with a serious medical condition(s)?

**Provider Vitality**
Small Group Exercise
Large Group Debrief

Measuring Person-Centered Care in Serious Illness

Collaborative Approach
• Across all participating organizations
• Learn from each other
• Define a short list of indicators
• Agree on a set of metrics
• Collect data
• Publication


