

National Share the Experience 2018

— Abstracts —

Thursday, October 25, 2018

Interest Groups

1. First Steps Organizational Faculty
2. Next Step Organizational Faculty
3. Physician and Advanced Practitioner
4. ACP leadership Program Implementation

Plenary Session

Updates in Advance Care Planning Measurement and Evidenced-Based, Patient-Facing Tools

Rebecca Sudore, MD, Professor of Medicine, University of California, San Francisco

Outcomes:

1. Explore creation of a standardized definition of advance care planning and the use Delphi panel procedures.
2. Describe an Organizing Framework for advance care planning outcomes and validated and practical tools to detect behavior change in advance care planning.
3. Explain the design, implementation, and measurement of easy-to-use, patient facing advance care planning tools, particularly for vulnerable and disenfranchised populations.

Abstract Description:

Over the past decade the ACP field has evolved and broadened its focus to include preparation of patients and surrogates to participate with clinicians in making informed medical decisions that are aligned with patients' current values and wishes. The field has also evolved to consider ACP as a process that involves a series of discussions over time in addition to a single advance directive or a one-time code status order. This session will provide an overview of: (a) the evolving ACP field; (b) an updated definition of advance care planning; (c) consideration of validated and practical tools to measure advance care planning; and (d) discuss the evidence-based, patient-centered PREPARE For Your Care ACP program (www.prepareforyourcare.org) and tools that can be used in the clinical, research, and community environment to promote ACP engagement, particularly for vulnerable and disenfranchised populations.

Concurrent Sessions 3

1. Community Engagement and organizational and System Strategies Using Technology

Community Engagement: Supporting Patients Through the Continuum of Care

Kellie Durgan, BSN, RN, Manager, Advance Care Planning, Providence Health Care

Outcomes:

1. Identify strategies that support an ongoing process of communicating the patient's story from acute care to home and primary care
2. Describe at least one EMR documentation redesign approach that keeps an individual's goals, values and preferences accessible at the center of care.

Abstract Description:

We often live in a very siloed environment in health care. Patients, particularly as they get sicker, move from one location of care to another without a clear way to consistently provide goal-driven care. This can be exacerbated when they are not able to advocate for themselves or lack a present and motivated person to advocate for them. How can we provide "warm handoffs" that help carry and continue the advance care planning (ACP) conversation as the patient moves from primary care to acute care and often back again?

This presentation will describe how a collaborative approach between a hospitalist group, primary care, home care and an in-hospital RN ACP coordinator worked together to establish consistent communication workflows that supported person-centered ACP conversations across the care continuum.

Using a single electronic medical record (EMR) across care setting is a critical element that allows for consistent communication of person-centered ACP conversations and language across settings. We will illustrate the documentation model we utilized and how caregivers from hospital to home care to primary care can review and continue important aspects of shared decision-making.

As patients are encouraged to share what they value, plans can be made to honor those wishes with careful attention from the caregivers who intersect with these patients at varying points of the care continuum.

Redesigning Patient-Centered Care: A NYC Health System's Commitment to Advance Care Planning

Christine Wilkins, PhD, LCSW, Advance Care Planning Program Manager, NYU Langone Health; Kevin Hauck, MD, MPH, Hospitalist, Instructor (Dept. of Medicine), NYU Langone Health; Tom Sedgwick, LCSW, CCM, Senior Director of Social Work, NYU Langone Health

Outcomes:

1. Describe strategies that support collaboration and accountability among team members to dissemination person-centered care.
2. List the key components to creating an advance care planning navigator in the medical record and a reliable electronic storage and retrieval system for eMOLST.

Abstract Description:

Despite increased efforts, advance care planning (ACP) in New York City is often an after-thought, brought up when patients are at end of life, and not 'in advance' of serious illness complications or

sudden events. This approach inevitably contributes to the distress experienced by patients, loved ones and staff members, who in addition to coping with a patient's worsening condition and impending death, also need to address what the patient wants or would have wanted had they been able to share with us their preferences for end of life care. To help address this gap in person-centered care, our academic medical center launched the Advance Care Planning Program, with full support from senior leadership. This presentation will describe our health system's strategy for implementing enterprise-wide advance care planning that promotes person-centered care. Implementation of the Respecting Choices First and Last Steps Programs will be highlighted. An overview of the changes to the electronic medical record, including the creation of the Advance Care Planning Navigator, Advance Care Planning Note, and change in code status order will be provided. Integration of New York State's electronic Medical Orders for Life Sustaining Treatment (eMOLST) will be described. Strategies for patient and staff education will be delineated. Efforts that maximize collaboration and that promote accountability among team members for enhancing coordinated advance care planning will also be shared.

2. Customization of ACP for the Pediatric Community

Improving Family Health Outcomes Through Pediatric Advance Care Planning (pACP) for Adolescents Living with HIV/AIDS

Christopher Lin, BA, Special Category Research Volunteer, Center for Translational Science, Children's Research Institute, Children's National Health System; Maureen E. Lyon, PhD, ABPP, Professor of Pediatrics, Children's National and George Washington University School of Medicine and Health Sciences; Yao I. Cheng, MS, Data Analyst, Children's Research Institute

Outcomes:

1. Describe the effect of pediatric advance care planning on family decision-makers' emotional health outcomes and the implications for clinical practice.
2. Discuss the implications of decreased family anxiety after facing the fear their child's medical condition could worsen (exposure therapy), as a theoretically expected response from the perspective of transactional stress and coping through problem-solving.

Abstract Description:

Surrogate decision-makers of end-of-life (EOL) care are more likely to experience stress and negative emotions, such as helplessness, anxiety and depression, than surrogates who made decisions for those who had an advance care plan. This presentation will share results of a Longitudinal, single-blinded, multi-site, randomized controlled trial was conducted in six hospital-based pediatric HIV-clinics that investigated whether or not the FAmily CEntered (FACE) pACP intervention improves emotional health outcomes for family decision-makers of adolescents with HIV/AIDS 3-months after the intervention.

HIV adolescent/family dyads (n=105 dyads) were randomized to either the weekly 3-session FACE pACP intervention or Healthy Living Control. The *Beck Anxiety Inventory and Beck Depression Inventory II* measured symptoms. Linear regression assessed the effect of the FACE pACP adapted Next Steps: Respecting Choices program on families' anxiety and depression, compared to the controls.

We found that the retention rate was 80% (n=84 adolescent/family dyads). Families: mean age, 44.9 years; 18% males; 90% black; 33% full-time employed/self-employed; 40% received high school diploma or GED; and 37% were HIV-positive. Controlling for baseline, families' anxiety at 3 months post-intervention in FACE was significantly lower than HLC ($\beta=-4.8$, $p = 0.0066$). Controlling for baseline, families' depressive symptoms at 3 months post-intervention in FACE also was lower than HLC, but not statistically significant ($\beta=-2.1$, $p = 0.2388$).

In conclusion FACE pACP significantly alleviated families' anxiety. The practical implementation of structured pACP by certified facilitators, involving patient-centered pACP conversations between adolescents living with HIV/AIDS and their families, is beneficial to families' health compared to the current standard of care.

Longitudinal Satisfaction and Preparedness among Adolescents Living with HIV: Family CEntered (FACE) Pediatric Advance Care Planning (pACP)

Isabella Greenberg, MPH, Special Category Research Volunteer, Children's National Medical Center; Maureen Lyon, PhD, ABPP, PI, Children's National Medical Center; Yao Cheng, MS, Biostatistician, Children's National Medical Center

Outcomes:

1. Identify the gaps in research for satisfaction/preparedness of pediatric advance care planning population in adolescents living with HIV.
2. Describe age-specific differences among younger and older adolescents living with HIV and discuss developmentally appropriate implications for clinical practice of pediatric advance care planning.

Abstract Description:

Despite advances in HIV/AIDS treatments, adolescents with perinatally acquired HIV have a high risk of morbidity and mortality¹, making adolescent-centered/family-engaged pACP appropriate. This presentation will describe the research results of longitudinal, single-blinded, multi-site, randomized trial conducted in six pediatric hospital-based HIV-clinics and the efficacy of FACE pACP on adolescent-reported satisfaction/preparedness among adolescents living with HIV.

The data presented will include a summary of the preparedness questionnaire administered 3, 6, 12, and 18 months post-intervention. Compared to younger adolescents (14-17 years): Older adolescents (18-21 years) were 4.4 times more likely to feel *ready for future decision making* at 6 months (95% CI odds ratio (OR)= [1.4, 14.3]); 6.3 times as likely to feel *more confident in my ability to face the future* at 12 months (95% CI OR=[1.4, 27.3]); and 8.2 times more likely to feel that *if something unexpected comes up, we could talk it through* (95% CI OR=[1.5, 46.5]).

FACE did not have an effect on longitudinal satisfaction/preparedness, family-engagement had significant effects on older adolescents' perception of preparedness for future medical decision-making, which increased over time.

3. Customization of ACP for the Rural Community

Lighting a Fire for Life Care Planning in Rural Colorado

Nancy L. Greenstreet, LCSW, Program Specialist, Kaiser Permanente Colorado; Brianna Kirkland, RN, Senior VP, Sangre de Cristo Hospice & Palliative Care

Outcomes:

1. Describe the rationale for selecting a rural community for implementation of a First Steps ACP program
2. Identify three implementation strategies, including education and outcomes measurement

Abstract Description:

Sangre de Cristo Hospice & Palliative care in collaboration with kind support from Kaiser Permanente chose to impact rural Southern Colorado through Advance Care Planning initiatives.

The prevalence of Advanced Directives with informed, intentional, and documented conversations in Southern Colorado, a culturally diverse community are rarely found and/or are often overlooked due to a lack of resources, geographic area, and uninformed regarding advance directives conversations (2017-2019).

We chose to outreach the normal healthcare providers such as: specialty clinics, hospitals, assisted living/independent living residences, and long-term care facilities in the community. We also chose outreach community through spiritual leaders, educators (University/Community College), first responders and local rotary organizations.

This presentation will describe the strategies used to implement a First Steps (FS) ACP program within this rural setting, to include gathering baseline data, FS Facilitator education, and outcomes collected to date. We are at the beginning of the implementation of research and we are already discovering the impact that lighting a fire in rural Southern Colorado as evidenced by the community receiving and accepting education and the number of informed, intentional conversations being held.

Building an Advance Care Planning Team in a Rural Community

Sara E. Hawreliak, RN, BScN, Patient Support Volunteer and ACP Facilitator, Pullman Regional Hospital; Sandy O'Keefe, BS, OCN, RN, Pullman Regional Hospital; Jessica Rivers, BSW, Care Coordinator and ACP Coordinator, Pullman Regional Hospital; Ann Williams, BScN, Patient Support Volunteer and ACP Facilitator, Pullman Regional Hospital

Outcomes:

1. Explain the value of addressing the spiritual/religious and cultural needs of the individual.
2. Delineate religious and cultural differences and how they may affect Advance Care Planning.
3. Identify potential barriers in Advance Care Planning with those from non-western cultures and various faith groups.

Abstract Description:

Healthcare is most effective when delivered in collaboration with patients and families. Health services must provide good medical treatment; improve patients' knowledge and self-management skills by supplementing medical care with educational and cognitive behavioral interventions. Patient-centered care (PCC) responds to individual patient preferences, needs, and values. Advance care planning (ACP) involves discussions between patients, families and providers on future healthcare decisions.

This presentation will describe how we incorporated collaborative care and PCC values in our community ACP program, beginning with a pilot study to enhance ACP awareness. Areas of focus were: training ambassadors; implementing services; team building; adjusting and adapting; maintaining passion for the work; measuring impact. Presenters will identify strategies to develop and implement an information campaign to increase awareness of services within hospital departments and the community and measurement of the impact of this campaign that surveyed participants.

4. Customization of ACP in the Mental Health Community

Advance Care Planning Discussions in a Drug Addiction Recovery Program

Thomas Kuczmarski, Medical Student, Geisel School of Medicine at Dartmouth; Nayan Agarwal, Medical Student, Geisel School of Medicine at Dartmouth

Outcomes:

1. Identify the person-centered advance care planning gaps that exist in the underserved population in New Hampshire
2. Explain how individuals in a drug addiction recovery program respond and react to advance care planning discussions
3. Describe at least one strategy to engage individuals in a drug addiction recovery group to participate in person-centered advance care planning conversations.

Abstract Description:

Advance care planning is found to be beneficial for both patients and their families when making health care decisions. Unfortunately, there are a surprisingly large number of individuals who have limited access or understanding of advance care planning. This presentation will describe the gap that exists across all populations, regardless of socioeconomic, geographic, or ethnic backgrounds and if some populations have more access to and a better understanding of advance care planning. We will further describe the advance care planning experience of 58 individuals participating in a rehabilitation program recovering from substance abuse therapy for opiate use in New Hampshire. We engaged 58 individuals in conversations involving icebreaker questions around end of life issues and introduced them to person-centered advance care planning. We then surveyed them about the session and their experience with advance care planning. We found that over 86% of the participants had never previously attended a presentation about advance care planning. 98.2% of participants said that they found our session useful and 44.5% of the participants said they felt either very confident or somewhat confident that they were going to complete an advance directive in the next 30 days after our session.

Our project has helped identify target populations in NH with lower advance care directive completion rates. In particular the population of individuals recovering from substance abuse are not only interested in advance care planning but will also benefit a lot from advance care planning conversations because of their vulnerable backgrounds.

Destigmatizing Mental Health Advance Directives

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

Outcomes:

1. Summarize the Michigan legal statues regarding Mental Health Advance Directives.
2. Describe the general treatment decisions listed in the Mental Health section of the Making Choices Michigan Advance Directive.
3. Explain how use the Mental Health Advance Directive Guide to assist patients with document completion.

Abstract Description:

The ability to participate in medical decision-making is essential to the provision of Person-Centered Care. In Michigan, the right to appoint a surrogate decision-maker through the creation of a Durable Power of Attorney for Healthcare is established by the Estates and Protected Individuals Code (EPIC). Most Advance Care Planning (ACP) providers are familiar with the provisions pertaining to healthcare decision-making, but many are far less comfortable with those relating Mental Health (MH). This discomfort often leads to MH decisions being completely left out of the ACP conversation. Treating the whole person requires understanding that attending to the psychiatric needs of the patient are just as important as attending to their physical needs. This presentation will review the statutory provisions in EPIC related to MH surrogate decision-making,

summarize the MH treatment options typically addressed and present a tool to facilitate understanding and completion of advance directives for MH.

5. Quality Improvement/Research – ACP/SDM and measuring the Quadruple Aim

Development of a Survey to Assess Practices of Shared Decision Making in Serious Illness (SDMSI) Course Participants

Christine Swift, RN, MSN, Manager, Community Medical Centers; Robin L. Whitney, PhD, RN, Assistant Adjunct Professor, Internal Medicine, University of California–San Francisco, Fresno

Outcomes:

1. Identify strategies to measure SDMSI practice among providers from their site.
2. Describe recent survey results of clinician attitudes, behaviors and implementation barriers of a SDMSI practice to support local implementation needs and opportunities for growth.

Abstract Description:

Shared Decision Making in Serious Illness (SDMSI) is a skills-based curriculum for providers offered by organizations who have met the implementation requirements of the SMDSI program. Our site has four SDMSI certified instructors and holds courses quarterly. However, we did not know how healthcare providers were using their new skills in practice after course completion.

This presentation will describe how a small, interdisciplinary work group was formed to develop a survey for course participants. The survey will examine the attitudes and behaviors of SDMSI course participants, identify implementation barriers, and assess fidelity to the SDMSI conversation guide in a 3-6-month timeframe post course completion. Survey development was an iterative process. Input was gathered from Respecting Choices team members and SDMSI certified instructors across multiple sites to assure survey responses would generate actionable information. Efforts are underway to partner with additional SDMSI organizations and make this a multi-site study.

Results of the survey will shed light on the real-world experiences of health systems after implementing SDMSI curriculum and can be used to help inform SDMSI implementation strategies. Our hope is that each SDMSI site will be able to use its own data to identify local implementation needs and opportunities for growth.

Using Technology to Bridge Delivery Gaps in Person-Centered Advance Care Planning

Arul Thangavel, MD, Vice President of Clinical Strategy, WiserCare

Outcomes:

1. Identify the common barriers that prevent consistent deliver of quality ACP services.
2. Describe technology strategies that focus on patient engagement, increase physician accessibility of ACP information, support the role of the health care agent, and assist in aligning care with individual goals.
3. Understand the supporting practices and processes that accompany technological tools to deliver a complete and scalable ACP solution.
4. Review case studies, learnings and results from organizations who have used these tools, strategies and processes.

Abstract Description:

Person-centered decision-making, enabled through Advance Care Planning (ACP), has gained traction as an intervention that aligns patients, providers, health systems and payers in achieving better health outcomes at a lower cost than default medical care. When defined narrowly as the completion of Advance Directives, living wills or POLST forms, ACP often fails to achieve the key benefits it promises: to align care with individual goals, values and preferences. However, when envisioned more broadly as frequent, substantive conversations between relevant stakeholders in a patient's health, ACP aligns care with patient preferences, *and* yields up-to-date legal documents, while also improving provider satisfaction and reducing cost. Despite these well-recognized benefits, several barriers to quality ACP persist, 1) Reduced patient engagement, 2) Physician distrust of Advance Care Planning process and outputs, 3) Incorrect proxy decision making, and 4) Family member misalignment.

This presentation will examine each of the above barriers and review tools and strategies that can overcome these barriers to support successful ACP implementation and scaling, including:

1. Patient engagement: Digital conversation tools supported by data-driven engagement mechanisms at multiple points in time
2. Physician acceptability of ACP information: Electronic auditing of the ACP process, evidence of proxy and family engagement, reliability and timeliness of output
3. Health Care Decision Maker alignment: Electronic educational and conversation tools
4. Non-Decision Maker alignment: Electronic educational and conversation tools

6. Optimization of ACP and SDM Reimbursement Opportunities

The Currency of Advance Care Planning: From Practice to Payment

Lynda Tang, DO, Chair, Department of Palliative Medicine, The Vancouver Clinic; Katie Pence, PA-C, Internist, The Vancouver Clinic

Outcomes:

1. Describe the methodology used in this study as an example for integrating ACP discussion into a primary care annual comprehensive visit.
2. Identify the criteria to satisfy billing for ACP discussion in a primary care annual comprehensive visit.

Abstract Description:

The Vancouver Clinic (TVC), a large physician-owned multispecialty outpatient clinic, is one of the early adopter cohorts of Honoring Choices Pacific Northwest: First Steps, which has a goal of documenting advance directives (AD) for 75% of Washington state residents by the year 2021. Advance care planning (ACP) discussions are an important step to achieving that goal but only a fraction of these discussions occur due to constraints on time and training.

This presentation will describe results from a prospective cohort study we conducted in July 2017 on the effect of educating TVC primary care providers (PCPs) on the clinical and remunerative benefits of adding ACP to annual comprehensive visits (ACVs) on the rate of billed ACP discussions, measured by Current Procedure Terminology (CPT) code 99497. We found that over the initial six-month study period, 7.2% of ACVs had ACP billed. Nineteen out of 59 TVC PCPs billed at least one ACP discussion for a total of 212 ACP discussions. These providers had 988 ACVs out of a total of 2940 ACVs performed by all providers. ACP billing provided approximately \$20000 in revenue.

The limitations on this study prompt additional work through chart review to determine whether non-billable ACP discussions are occurring at ACVs and whether ACP discussions increase the rate of documented advance directives.

We conclude that educating PCPs on the benefits of ACP and providing them with the framework to do so within an ACV encouraged additional ACP conversations, as measured by ACP-specific billing.

Collaboration Enables Advance Care Planning (ACP) Conversations, Sustains ACP Billing, and Keeps Patient & Physician at Center of Process

Betsy Payne, MSN, RN, Executive Director, Looking Ahead Advance Healthcare Planning

Outcomes:

1. Describe strategies to collaborate with physician offices to provide assistance in advance care planning conversations to support ACP billing.
2. List the team-based roles, responsibilities, and steps to a collaborative ACP process that supports ACP billing practices.

Abstract Description:

The long-term sustainability of providing assistance in person-centered advance care planning (ACP) conversations is challenging within the current healthcare environment. *Looking Ahead, Inc.* a community-based, independent nonprofit, supports a team-based approach of ACP conversations for individuals with chronic healthcare needs with the goal of increasing the number of documented ACP conversations and advance directives filed with their hospital and primary care physician (PCP). Recognizing the significant role that primary care physicians have in this process, we collaborated with Doylestown Health to develop a pilot using a Risk Assessment Dashboard to identify and invite patients to participate in ACP conversations.

This presentation describes how *Looking Ahead, Inc.* contracted with each PCP office to facilitate ACP conversations, document conversations in the medical record, guide individuals to complete advance directive documents, and support physician billing for ACP services. Presenters will provide a) strategies to engage PCP offices in establishing collaborative relationships to assist with team-based ACP services and ACP billing, b) examples of workflows that support office-based ACP conversations by ACP facilitators and reporting ACP CPT codes by physicians, and c) the general framework for an analytical dashboard for ongoing measurement. Lastly, we will share recent results from our pilot and plans for collaborating with other PCP offices and Medicare Advantage programs.

Workshop Sessions 2

1. Synergies of Collaboration Across Person-Centered Advance Care Planning and Shared Decision-Making Programs (two-part workshop)

a. Initiating Advance Care Planning (ACP) in Primary Care: A Model for Widespread Success

Stephanie Leung, MBA, Project Specialist, Hospice of Cincinnati; Barbara Rose, MPH, RN, Senior Project Administrator, Community Programs, Hospice of Cincinnati

Outcomes:

1. Describe how the Respecting Choices Last Steps® and VitalTalk® curriculums can be combined to train staff in the primary care setting to help implement advance care planning into the workflow.
2. Identify at least two examples of electronic medical record enhancements that can be integrated into a health system to impact the long-term sustainability of person-centered advance care planning.

Abstract Description:

Primary care providers (PCP's) recognize the importance of person-centered advance care planning ACP conversations and their role in having them. PCP's report barriers to having these conversations that include not having adequate training, not knowing what to say, not having enough time and patient-family member conflict¹. For ACP to succeed, better clinician communication skills are necessary². There are few documented models of successful initiation of advance care planning (ACP) in primary care offices. Conversations of a Lifetime® (COL), a Hospice of Cincinnati program and part of the TriHealth system, combined multiple evidence-based modalities to initiate ACP in 36 TriHealth primary care practices.

This presentation will describe how RN care managers in practice identify appropriate patients, facilitate Last Steps person-centered ACP conversations, and serve as a resource to help complete advance directive documents. Presenters will describe how VitalTalk® was utilized to create a custom coaching curriculum for physicians to feel more confident about initiating ACP conversations with patients and families. (see *VitalTalk Materials*). Lastly, a description of the use of an ACP Nurse Liaison can provide technical support to optimize workflows and EMR documentation. During this project Electronic Medical Record (EMR) enhancements (an ACP Summary Report, ACP Best Practice Alerts) were used to support the work.

As a result, Last Steps ACP conversations initiated and documented increased in 36 primary care practices with a combination of communication coaching, staff training, RN technical support and EMR enhancements (Intervention period: May 2014 – Dec 2016; 7,199 conversations). ACP conversations sustained (Post-Intervention period: Jan-Dec 2017; 7,589 conversations). (see *Results Graph*)

b. Exploring Collaboration Between the Respecting Choices Program and the PREPARE For Your Care Advance Care Planning Program

Rebecca Sudore, MD, Professor of Medicine, University of California, San Francisco; Stephanie Anderson, DNP, RN, Deputy Executive Director, Respecting Choices

Outcomes:

1. Explore synergies between Respecting Choices and PREPARE
2. Explore the practical realities of using Respecting Choices First Steps and PREPARE together
3. Explore clinical and research design ideas and outcomes that would help define success of a synergistic program.

Abstract Description:

In this session we would like to provide information about the synergies between Respecting Choices and an evidence-based, patient-centered PREPARE For Your Care ACP program (www.prepareforyourcare.org). We would also like to discuss and obtain feedback from Respecting Choices users and stakeholders about the practical realities of using these two programs together

and how to best define success of such a merged program. This will be an interactive session in which we will be asking for brainstorming and input from our knowledgeable attendees.

2. The Honoring Choices Pacific Northwest Convener Model: A Closer Look

Jessica B. Martinson, MS, Director, Clinical Education and Professional Development, Washington State Medical Association; Kim Stagner, RN, CCM, Faculty, Honoring Choices® Pacific Northwest

Outcomes:

1. Cite three strategies used to recruit, engage, support, and celebrate partner organizations that are implementing the First Steps ACP program within their health care setting and broader community.
2. Learn about one design structure using the cohort and convener model to create a First Steps program including the approaches used for staffing, funding and the creation of short and long-term goals.
3. Identify three customized consulting and training strategies to address teams during the phases of implementation. (initial launch, spread and dissemination, ACP coordinator, facilitator and instructor development, ongoing leadership engagement, EMR integration and quality improvement)

Abstract Description:

- Outline the strategies used to recruit, engage, support, and celebrate partner organizations that are implementing the First Steps ACP program within their health care setting and broader community.
- Discuss the structure of Honoring Choices PNW, include the organizational chart, staffing (including contracted Faculty), funding model, and short- and long-term goals.
- Describe the cohort model used to on-board up to 32 teams at a time.
- Identify customized consulting and training strategies to address topics such as initial launch, spread and dissemination, facilitator and instructor development, leadership engagement, and EMR integration.
- Describe the roles and responsibilities of Honoring Choices PNW vs. participating organizations.
- Review the measurement tracking tool and submission form used by teams to track progress on 18 measures.
- Share the initiative's outcomes to-date and goals for the future

3. EMR Optimization for Decision Making and ACP

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:

The purpose of this workshop is to provide an 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 the details 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. Participants will have opportunity to network with other Epic users to collaborate on best practices, as well as to provide direct feedback to Epic about struggles and successes. 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.

4. How do you measure the 'Value' of Next Steps Advance Care Planning Conversations?

Carole Montgomery, MD, FHM, MHSA, Director, Physician Development and Program Improvement, Respecting Choices; Sandra Schellinger, MSN, APRN, NP-C, Senior Faculty and Consultant

Outcomes:

1. Describe the gap in advance care planning that is missing when individuals only complete only a First Steps and/or Last Steps ACP conversations
2. Describe the difference in the value proposition for organizations who provide Next Steps ACP conversation for individuals with serious illness compared to First Steps ACP and/or Last Steps conversations alone.
3. List key utilization outcomes and access to health resources following the Next Steps conversations compared to the First Steps ACP conversation.
4. Identify at least one metric for each quadrant of the quadruple aim that demonstrates the value proposition of NS ACP conversations.

Abstract Description:

A Next Steps ACP conversation helps these individuals to understand possible future complications based on their illness trajectory, to identify what they would consider an unacceptable outcome if those complications occur, and what their goals would be under those circumstances. Neither First Steps (FS) nor Advance Steps (AS) Advance Care Planning (ACP) conversations sufficiently address the person-centered decision-making needs of individuals who are engaged in active disease management and experiencing complications. A Next Steps ACP conversation creates the opportunity for individuals to actively engage in decision-making about disease-specific scenarios during treatment of their medical condition.

This workshop will provide an overview of the Next Steps ACP conversation and describe the gap that is missing in advance care planning when individuals only complete a First Steps and/or Advance Steps ACP conversation. Presenters will share their perspective on the measurable outcomes attributed to Next Steps conversations. Case studies will be used to a) describe serious illness situation-based and treatment decision outcomes in the presence and absence of a Next Steps conversation and b) describe how these outcomes align with the Institute of Medicine's Quadruple Aim. Lastly, participants will actively engage in small and large group activities to identify common, measurable quadruple aim metrics that can be used to demonstrate the value proposition of the Next Steps ACP conversation in their organization.

5. Understanding the Important Elements that Define Quality Patient Decision Aids

Laura Pennington, Practice Transformation Manager, Washington State Health Care Authority;
Linda Briggs, MSN, MA, RN, Director, Program Development and Research, Respecting Choices

Outcomes:

1. Identify a high-quality patient decision aid, applying a set of evidence-based certification criteria
2. Evaluate the difference between a patient decision aid and patient education materials
3. Understand the value of certification in ensuring PDA quality, and expectations for a certified aid
4. Recognize the key elements in a PDA which are most critical to supporting good shared decision making
5. Describe a four-phased approach to developing certified decision aids

Abstract Description:

Patients often face complex healthcare decisions where the path chosen may have important and lasting consequences. When faced with these important decisions, patients must consider personal circumstances, values, and preferences to make the “best choice” for themselves.

When effective two-way communication occurs, better informed, more person-centered decisions result. Good shared decision-making requires three main components: clear, accurate and unbiased information about all available options, including risks versus benefits; clinician investment and expertise in engaging and communicating with patients; and the effective communication of patient values, goals, informed preferences and concerns with the health care team. Patient decision aids (PDAs) are tools designed to help in this process. PDAs can help people engage in shared health decisions with their health care provider. Research shows that use of high quality PDAs leads to increased knowledge, more accurate risk perception, and fewer patients remaining passive or undecided about their care.

As part of its Healthier Washington initiative, Washington State has developed and implemented a process of certifying PDAs to help assure they are effective, accurate, unbiased tools for providers to use as part of the shared decision-making process.

This interactive workshop will walk participants through the key elements in a high-quality PDA, building upon the certification criteria used in Washington, which were adapted from the International Patient Decision Aid Standards (IPDAS) Collaborative. Participants will have an opportunity to practice applying the certification criteria to a PDA to increase their understanding of how to identify a high-quality PDA. Presenters will share one organizations experience in developing decision aid and the certification process.

Plenary Session

Pediatric Advance Care Planning: A Panel Presentation on the Power of Research, Clinical Implementation, and the Caregiver Experience

Maureen E. Lyon, PhD, Children’s National Health System, Washington, DC; Jon Sande, MD, Essentia Health Care, Duluth, MN; Kate Detwiler, Parent; Linda Briggs, MSN, MA, RN, Director, Program Development and Research, Respecting Choices (Moderator)

Outcomes:

1. Identify two obstacles in conducting ACP research in the adolescent population
2. Explore the challenges and opportunities in clinical implementation of a pediatric ACP program
3. Recognize the importance of ACP conversations for parents of children with life threatening illnesses

Abstract Description:

Although advance care planning (ACP) principles, laws and implementation strategies originally were focused on adults over the age of 18 years, the need for a similar planning process for the pediatric population and its parents, has become a national imperative. In the U.S., as many as 1 out of 4 children live with a chronic condition. Over 13,000 children in the U.S. are diagnosed with cancer each year (van Cleave et al. 2010; Van der Lee et al. 2007). For over a decade, Respecting Choices has collaborated in research and clinical implementation to adapt its ACP principles and strategies to the pediatric population. This facilitated presentation will include a panel discussion among three individuals who have been active partners with Respecting Choices in pediatric ACP: a researcher, a physician leader, and a parent. The challenges in conducting research and initiating a clinical pediatric ACP program will be explored. The caregiver experience will be discovered through the eyes of one parent of a child with a life-threatening illness. These panelists will share their personal perspectives of what has been learned, what is needed, and how their collective perspectives can inform the future of pediatric ACP.

Concurrent Sessions 4

1. Organizational and System Strategies of Integrating Workflows into Existing Initiatives

Collaboration Between a Hospital System and Area Retirement Communities to Enhance Person-Centered Advance Care Planning Conversations

Deborah Heisey, MSN, RN, ACM, Community Care Manager, Lancaster General Health/Penn Medicine; Kristen Klopp, MSN, RN, CCM, Community Care Manager, Lancaster General Health/Penn Medicine

Outcomes:

1. Analyze the impact of an ACP collaborative between a healthcare system and a preferred provider network to implement Respecting Choices within community retirement centers and extended care facilities.
2. Describe three implementation strategies to provide education, engagement and workflow redesign.
3. List long term ACP outcomes achieved as a result of the collaboration between a health system and preferred provider network.

Abstract Description:

Residents of continuing care retirement communities and skilled nursing facilities may complete advance directive documents as part of an admission process, but often miss the opportunity to have conversations around values and preferences. Neglecting to engage these residents and their families in Advance Care Planning (ACP) can have devastating results, potentially resulting in unwanted medical care and unnecessary readmissions to the hospital¹.

This presentation will describe how one health system collaborated with its Preferred Provider Network (PPN) to create an inter professional task force to implement Respecting Choices ACP within the continuing care retirement communities and extended care facilities. Implementation strategies included staff education on the Respecting Choices model at each facility, resident and family engagement in person-centered conversations, and consultation to assist with workflow redesign. The presenter will describe the outcomes achieved, to include educational accomplishments, an engagement “tool kit” for patients and staff, and a reduction in readmission rates.

Expanding our ACP Program to Employees and Employers Through a Partnership with General Electric (GE)

Jennifer A. McCalley, MSW, ACHP-SW, Program Coordinator Honoring Care Decisions, Dartmouth Hitchcock; Teryl L. Desrochers, RN, BSN, Program Coordinator Honoring Care Decisions, Dartmouth Hitchcock

Outcomes:

1. Identify two new strategies that you might incorporate into your internal ACP processes to improve the health of your employees.
2. Identify two businesses you may want to partner with to improve the health of their employees.

Abstract Description:

Before our participation in HCLA 2017 (Healthy Cities Leadership Academy through General Electric), we were focused mainly on bringing person-centered Advance Care Planning (ACP) to our patient population. This award helped to remind us that there are many faces of a community and included are **our** employees as well as other employers. This presentation will describe our experience in developing implementing an employee wellness program that include the offering support of facilitated ACP conversations and introduce new opportunities to improve health. Prior to our HCLA project, our attempts to introduce ACP at the workplace were disappointing with low levels of employee participation.

Honoring Care Decisions, Employee Wellness, Human Resources and Population Health sought ways to make ACP routine and easy using the \$25,000 grant awarded by GE. With the help of Partners for Community Wellness, we were able to expand to other employers in the state as well.

We used the funds to:

- Create an ACP e-learning
- Provide refreshments at employee Group ACP Conversations
- Add ACP offerings to Live Well Work Well (LWWW) Health Improvement Programs
- Add the option to sign up for ACP assistance via benefits open enrollment.
- Partner with Prepare for your Care®, an online advance care planning tool
- Collaborate with area businesses to offer ACP services and provide refreshments

2. Workforce Development and Interprofessional Practice

Using the Principles of Emotional Intelligence to Increase the Confidence of Lay/Volunteer Facilitators in Community Settings

Patrice Tadel, MSN, RN, Senior Faculty Consultant, Respecting Choices

Outcomes:

1. Define Transformative Learning and Emotional Intelligence (EI) and how each builds a framework for communication competence
2. Apply concepts discussed to support ongoing self-journey as an instructor and a process with no end for learners by using emotional intelligence to grow in the role of Facilitator
3. Express strategies to teach and apply principles of EI, such as self-awareness, intentional reflective behavior, and expression of empathy.

Abstract Description:

In a literature review, the role of Emotional Intelligence (EI) has been demonstrated as effective for instructors and learners alike. EI includes various skills to allow the learner to have confidence when engaging and responding to persons and changing situations. Using a framework that builds on specific emotional skills can support the novice Facilitator when engaging in what some refer to as “intimate” conversations with individuals during facilitated person-centered advance care planning (ACP) conversations. Building on the principles of Transformative Learning (TL), learners and instructors actively engage in interactions which include self-assessment, self-development and self-improvement. The intentional use of specific EI skills can help to develop confidence in the lay/volunteer facilitator during person-centered ACP conversations. The speaker will define TL and a framework for EI that can be used to minimize negative stress and contribute to effective learning of communication skills which foster the ACP facilitated person-centered conversation. Respecting Choices experiences with teams that build on the unique qualities and challenges which may present when utilizing lay/volunteer facilitators will be highlighted as part of this discussion.

Advance Care Planning for Health Care Professional Students: Essential Content for Novice Health Care Providers

Nancy A. Hall, DNP, RN, Associate Professor, Nursing, Bemidji State University

Outcomes:

1. Explore the role and responsibilities of the ACP coordinator which support a sustainable ACP program.
2. Describe two or more ways an ACP program benefits from leadership and oversight of an ACP Coordinator.

Abstract Description:

The delivery of person-centered care at a time when an individual is unable to speak for themselves requires surrogate decision makers and health care providers to have a clear idea of an individual’s goals, values and preferences for care. The Patient Self Determination Act provides for the completion of advance directives, yet many American adults do not have a directive in place (George, 2018). Social workers, nurses, physician’s assistants, and physicians can also influence decisions that honor advance directives in the provision of care. American Nurses Association (ANA) standards describe the nurse’s role in supporting end of life decision making (ANA, 2016). Quality and Safety Education in Nursing (QSEN) standards also address the need for the acquisition of knowledge, attitudes, and skills related to the provision of patient centered care, including decision making focused on patient’s values and preferences (QSEN, 2018). Gaps have been identified in health care professionals’ knowledge and ability related to person-centered advance care planning, including limited exposure to the subject during their pre-licensure education (IOM, 2015).

This presentation will propose essential content for inclusion in the basic education of health care professionals. Alignment with key curricular concepts such as therapeutic communication, ethical principles, informed consent, person-centered decision-making, and palliative care will be highlighted. Suggested learning activities related to essential aspects of person-centered advance care planning and decision-making will be included.

3. Quality Improvement and Research

The A-Ha's from Concordance Reviews, a Lifetime of Learning

Bridget A. Darden, MAOM, BSN, RN, C-RC Org Faculty, Life Care Planning Next Steps and Advanced Steps Faculty, Kaiser Permanente Colorado

Outcomes:

1. Describe one organization's quality improvement study to measure concordance of care delivered to documented preferences.
2. Identify two organizational initiatives that emerged from the quality improvement study to measure concordance of care delivered as compared to documented preferences.

Abstract Description:

In one article Concordance of Care it is explained, "Concordance does not refer to a patient's behavior, but rather the nature of the interaction between clinician and patient. How individual patients value the risks and benefits of a particular care plan or treatment approach may differ from the value assigned by their clinicians. In adopting a concordant approach, clinicians should respect the rights of patients to decide whether or not to engage with a suggested plan of care." Concordance is synonymous with patient-centered care." (NHS Foundation Trust, 12/16).

At Kaiser Permanente Colorado (KPCO) concordance of care was not reviewed prior to first quarter of 2015. Concordance of Care is an ongoing quality initiative for our Life Care Planning (LCP) department and Organization. Retrospective individual charts are reviewed for several factors that influence quality of care (patient centered care with shared decision making), satisfaction (individual, family, and employee) and system infrastructure (workflows, documentation practices, and storage/retrieval of documents). This process is continual evolving as new opportunities present themselves.

This presentation will describe the target population, tools, methodology and outcomes our quality improvement study that measured concordance of care delivered as compared to documented preferences. The presenters will describe 7 quality initiatives identified as a result of this study.

The Results and Impact of a Death Chart Audit in an Academic Health Care System

Sanders Burstein, MD, FAAFP, Medical Director, Honoring Care Decisions Dartmouth-Hitchcock, Consulting Independent Contractor, Respecting Choices

Outcomes:

1. Perform a death chart audit to identify and improve person-centered advance care planning outcomes.
2. Understand the results and impact of a death chart audit tool in a large health system with the intent of improving person-centered policy, procedure and educational opportunities for providers and staff.

Abstract Description:

In 2016, during a 4th year medical school course on Health, Society and Profession, eight medical students (Geisel School of Medicine, Dartmouth) were introduced to the principals of the Respecting Choices Person-centered approach to Advance Care Planning and Quality Improvement. Medical students completed a medical record to understand the how a death chart audit identified to improve advance care planning. This presentation will summarize the gaps in provider knowledge and compliance with New Hampshire Law which resulted in updated policies, procedures, plans for education of providers and staff, and a new “decision navigator” in the electronic health record.

4. Organizational and System Strategies of Integrating Workflows into Existing Initiatives

Making It Work: PlayBooks for Healthcare and Community Organizations

Bonnie Bizzell, MBA, MEd, ACP Program Manager and Lead Faculty, Honoring Choices Pacific Northwest; Kellie Durgan, BSN, RN, Manager, Advance Care Planning, Providence Health Care

Outcomes:

1. Understand the benefits of creating a PlayBook to support organizational person-centered ACP program implementation.
2. Describe the key similarities and differences between healthcare and community PlayBook models.

Abstract Description:

Providence Health Care in eastern Washington began First Steps® Advance care planning (ACP) clinic pilots in March of 2015. Honoring Choices Pacific Northwest began collaborating with community groups in Fall of 2017. In both settings, building lengthy Implementation Plans presented challenges. For Providence, the time requirement and significant work taxed already limited resources. For community groups, the upfront investment presented a considerable barrier to adopting the program. By implementing PlayBook models unique to each setting, organizations could more readily commit and implement a person-centered First Steps ACP program.

This concurrent session will:

- Explore the early thinking to revise the current Implementation plan into a binder with information/workflow sections and resources that could be individualized for specific healthcare locations, modeled after the Dartmouth-Hitchcock playbook.
- Identify unique needs and opportunities within community organizations in using a PlayBook model.
- Discuss the response and application of the PlayBook, including healthcare staff ownership, use, and adaptation of it.
- Describe the outcomes of utilizing a PlayBook model in a healthcare system, including creating a PlayBook model focused on group ACP conversations.
- Highlight the similarities and differences between the healthcare and community PlayBooks in best practices, comprehensive resources and workflows, and guidance to fully individualize the general plan for specific sites.

ACP is for ALL Adults: Our Employee Initiative

Chris L. Brinneman, MSW, LCSW, Manager ACP, Parkview Health; Amy L. Spallinger, MSW, LCSW, First Steps ACP Organization Faculty

Outcomes:

1. Identify at least two challenges unique to the implementation of a person-centered ACP workflow for employees/co-workers.
2. Describe at least one common goal shared by advance care planning and a comprehensive wellness program.
3. List the educational and support strategies that empower non-clinical ACP facilitators to provide person-centered ACP conversations with clinicians and peers.

Abstract Description:

As our health system began the design and implementation of Respecting Choices®, we quickly learned that normalizing advance care planning included promoting the concept that ACP is for all adults. We decided that “all adults” included the providers and co-workers who work in our health system, and so we began to create an ACP employee initiative.

This presentation will describe lessons learned and practical tips related to integrating a person-centered ACP into an employer wellness program. Because comprehensive wellness programs and ACP share a common goal of lowering health care costs we offered person-centered ACP opportunities as part of our employer-based wellness program and created the opportunity for team members to have ACP conversations utilizing wellness coaches as facilitators. which was developed for the long-term benefit of personal health and well-being. We will 1) describe the development of a process to offer person-centered ACP to health system providers and co-workers proved and 2) identify the challenging yet unique differences than designing processes for patients--how to invite co-workers to participate, who would be facilitating these conversations, where and when would these conversations could take place, and what to do with advance directive documents that could be created as a result of a person-centered ACP conversation.

5. Community Engagement

It Takes a Village—and More! The Formation of a Holistic Community Collaboration Around Advance Care Planning

Ellen H. Koski, MPH, CPH, Executive Director, Fox Valley Advance Care Planning Partnership; Teri G. Metropulos, MA, LPC-IT, Behavioral Health Counselor, Mosaic Family Health; Theresa M. Pichelmeyer, RN, MPA, Ed.D, President/CEO, Valley VNA Health System

Outcomes:

1. Identify key stakeholders necessary for successful community engagement around advance care planning.
2. Describe at least one collaborative strategy that can led to the development of the Fox Valley Advance Care Planning Partnership.

Abstract Description:

According to MacPherson & Parikh (2017), what makes Appleton, WI one of the best places to die in the U.S.? Quality metrics from the Dartmouth Atlas (2014) indicate Appleton and the Fox Valley area lead the state of Wisconsin in lowest number of residents dying in the hospital, least number of admissions to the hospital in the last six months of life and lowest inpatient spending in the last six months of life. We believe these local statistics have improved over time due to increased

community engagement and the strategic work with the health care systems and community partners.

In 2014, leadership from two large area health systems opened up conversation around a partnership with shared goals around advance care planning in the Fox Valley area. Formed in 2016, the Fox Valley Advance Care Planning Partnership---Health care providers, clergy, lawyers and community members---served as a catalyst for community action to develop collaborative, community-focused work that has benefited the access to person-centered advance care planning to all. This presentation will describe the story of the Fox Valley Advance Care Planning Partnership, key collaborations that led to success, lessons learned, and the future state of the Partnership.

Community Health Collaborative: Community and Leadership Engagement with ACP Focus in NY's Capital Region

Gwendolyn E. Bondi, MS Bioethics, Manager, Palliative Care, Visiting Nurse Service of Northeastern New York

Outcomes:

1. Identify three categories of employers who are effective in championing a regional ACP initiative.
2. Describe five strategies to establish, quantify and evaluate a community based person-centered ACP initiative that blends the strengths of a combined membership organization.

Abstract Description:

Recognizing the need to motivate and facilitate advance care planning (ACP) among New York Capital Region's community members and healthcare providers, a coalition of 15 major employers are collaborating on a project to improve quality of life by engaging and empowering the individual through person-centered ACP conversations. This collaboration is the first of its kind in the area aligned with ACP. While the project is underway and ongoing, its example as a case study in leadership engagement is its appeal. The project is designed to encourage ACP conversations between community members and their healthcare providers which helps employers and employees realize the positive impact of person-centered ACP conversation on their lives. The CEOs of the 15 organizations (marketplace competitors) made a commitment to work collaboratively with a Respecting Choices trained and certified First Steps ACP instructor to hold employee meetings, potentially impacting tens of thousands of people.

This concurrent presentation will describe (1) how employees of the member organizations are introduced to the community-wide strategy; (2) the baseline characteristics are collected and quantitized; (3) the measurement, evaluation, and impact of training sessions; (4) how the validation of the effectiveness of this approach is intended to engage university researchers and the school of public health; and (5) the quantified results of selected person-centered ACP outcomes. Four organizations are also overseeing the creation of a website to include community resources, complete an environmental scan of the four counties in the Capital Region for activities related to the goals, and generate new member involvement toward sustainability.

Plenary Session

The Naked Truth. The Price We Pay for Things Unsaid. An Advocate Speaks from Experience

Julie Wallace, Owner, Dog and Pony Communications, and Patient Advocate, Making Choices Michigan

Outcomes:

1. Describe the harm and negative effects on patients and families when care is delivered without the recognition of a patient's goals, values and wishes.
2. Recognize the positive effects and benefits of an individualized approach to care when personal goals, values and preferences drive care.

Abstract Description:

Most patients experiencing serious illness medical complications are in the intensive care unit and lack the ability to make their own decisions. Surrogate decision makers are often put in a place to make preference sensitive decisions when they are uncertain about their loved ones wishes.

Storytelling allows an individual to share what is most important to them through their own perspective allowing a two-way conversation that results in a shared understanding. Through storytelling, this session will share patient and families' ---good, bad, and ugly---experiences demonstrated with the presence or absence of a person-centered decision-making approach to care. These experiences will assist the learner to recognize opportunities to for person-centered family-oriented shared decision making.
