

National Share the Experience 2018

— Abstracts —

Friday, October 26, 2018

Interest Groups

1. Advanced Steps (formerly Last Steps) Organizational Faculty
2. ACP Research
3. ACP Leadership and Sustainability
4. Respecting Choices Instructors

Plenary Session

Making the Case for Certified Patient Decision Aids: Lessons from Washington State

Laura Pennington, Practice Transformation Manager, Washington State Health Care Authority

Outcomes:

1. Describe how shared decision making and certified patient decision aids can be used to promote person-centered care for patients with serious illness
2. Explain how certification is critical to ensuring patient decision aid (PDA) quality and accuracy
3. Explore Washington State's experience in certifying patient decision aids and implementing into practice

Abstract Description:

Patients with serious illness 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.

Shared decision-making is “an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences.” Good shared decision making requires access to clear, accurate and unbiased information about all available options, as well as clinician investment and expertise in engaging and communicating with patients to better understand and support decisions that consider their personal values, goals, preferences and concerns. Patient decision aids are tools designed to help in this process and can provide information about options, including risks versus benefits, and help elicit patient values and preferences.

Washington State has played a pivotal role in supporting patient-centered care through shared decision making by certifying patient decision aids to ensure they are effective, accurate, and unbiased, by supporting provider training, and by implementing pilot projects. Multiple

stakeholders in Washington have begun work to implement shared decision making and the use of certified patient decision aids.

This session will explore why certification is critical to ensure accurate, high quality decision aids, building upon the experience in Washington State and use of certification criteria, adapted from the International Patient Decision Aid Standards (IPDAS) Collaborative, to support patient-centered care for patients with serious illness.

Concurrent Sessions 5

1. Community Engagement

Community Education Partnering: Enhancing Local Education Efforts in Person-Centered Advance Care Planning

Barbara M. Carranti, MS, RN, Clinical Associate Professor, Department of Nursing, Le Moyne College

Outcomes:

1. Describe at least once collaborative strategy between organizations and local professionals that results in increased access to and participation in community based person-centered ACP.
2. Identify key stakeholders necessary to form community partnership when providing person-centered ACP education and resources.

Abstract Description:

Failure to complete person-centered advance care planning is often attributed in part to lack of education on options and process. Compounding this gap, care providers are ill-prepared to encourage patients and families to participate in this discussion. Through partnerships with key community organizations and professionals, this presentation will describe how local community efforts to provide and enhance education of citizens have increased person-centered advance care planning (ACP) and engaged them to become active partners with their providers to share in person-centered decision-making.

Staff members at a local care center attended First Steps Facilitator Training at a local college. This mission consistent effort enhanced an existing partnership between the organizations. This training offered the ability to use the education outreach structure of one organization and the education expertise of the other and to offer person-centered ACP sessions to the local community. These efforts allowed local professionals (attorneys, palliative care practitioners, spiritual leaders, gerontologists) to provide interested groups with comprehensive information about preparing for the future, advance care planning and facilitation services.

Improving Person-Centered Care Through Community Engagement and Collaboration

Catherine R. Bardier, MS, Director, Wellness and Community Health, New London Hospital/Dartmouth Hitchcock Affiliate

Outcomes:

1. Describe one approach that supports community engagement and outreach for increasing person-centered ACP conversations.

2. Identify one strategy to support ongoing collaboration with local community partners to increase access and participation in ACP conversations.

Abstract Description:

The New London Hospital ACP Team began its work in 2014. Initially, the focus area was on our 58-bed nursing home. We implemented the POLST program with our social worker and chaplain and had great success. Over the next few years the first steps program was implemented in outpatient, inpatient and surgical areas of the hospital and clinic. We are recognized in the state of New Hampshire as a leader in having ACP documentation in patient medical files.

In 2017, New London Hospital expanded the internal ACP team to include a community partner, Visiting Nurse Association and community volunteers. The aim for the expansion of the team was to bring our successful ACP work into the community vs. a more internally focused program at the hospital and rural health clinic. Our goal was to attract more ACP participants; especially those who would not be exposed in the hospital setting through outpatient or inpatient communication methods. What we have witnessed is an increase in community outreach and engagement. We believe our program is unique due to the cohesiveness of our community and collaboration between the hospital and the community partners. Fostering relationships and collaboration within the community has been the key to our success.

This presentation will share ways of successful community outreach and engagement through community presentations within the faith community, residential communities, libraries, Sr. Centers and school systems. We will describe key strategies organizations can use to reach out to community partner that supports the collaboration and expansion of person-centered ACP resources beyond an individual health system.

2. Quality Improvement/Research – ACP/SDM and Measuring the Quadruple Aim

Creating a Culture of Concordance—Inpatient Care at Providence Health Care in Eastern Washington

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.

Respecting Choices: What Does the Published Research Show?

Bernard Hammes, PhD, Executive Director, Respecting Choices

Outcomes:

1. List three outcomes Respecting Choices programs have demonstrated positive results that promote and support person-centered decision-making.
2. Describe two or more areas where additional research is needed to advance the field of person-centered advance care planning and decision making.

Abstract Description:

The Resecting Choices program, or parts of it, has been featured as an intervention in at least 34 peer-reviewed, published articles. What do the findings show? This presentation will summarize the findings to look at what we know; what is supported but still needs stronger evidence, and what still needs to be tested. The presentation will help summarize the strengths of evidence of the Respecting Choices program and address some of the criticisms of the program. Finally, the presentation will look at what research projects are currently underway or proposed to consider where are evidence base is headed. Will this new research result in answering the questions we need to answer?

3. Workforce Development and Interprofessional Practice

Mentoring New Facilitators and Instructors: Growing Your Own

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

Outcomes:

1. Identify two or more core concepts for mentoring which support development and growth of Facilitators and Instructors
2. Define the importance of mentorship for development of a professional identity for the lifelong learning of the mentor
3. Explore various mentorship techniques for embedding a sustainable standardized model for self-assessment and growth of Facilitators
4. Describe critical thinking opportunities as a framework for ongoing competence and confidence of mentor and mentee

Abstract Description:

The confidence and competence of a certified advance care planning (ACP) facilitator grows and develops with experience, after completing 10-12 person-centered ACP conversations, and through ongoing mentoring. Over time literature has defined mentorship as the facilitation of learning, supervision, and assessment of mentees in a practice setting. Recent authors have stressed the

importance of supporting the learner through a flexible approach to coaching which takes into account the student's unique abilities and confines. The presentation will describe the use of self-assessment and critical thinking strategies to encourage the mentee to analyze and problem-solve according to individual learning needs and learning style. In this way, a collegial atmosphere for self-development and reflection is established. Presenters will use specific exercises to foster this approach that can assure the ongoing personal and professional growth of Facilitators and Instructors.

Engaging People to participate in Advance Care Planning with Motivational Interviewing

Allan Zuckoff, PhD, VP, Clinical Program Development, Vital Decisions

Outcomes:

1. Recognize and explain the implications of ambivalence about person-centered ACP in people with serious illness.
2. Describe the evidence-based conceptual framework of motivational interviewing for enhancing readiness to engage in ACP conversations.

Abstract Description:

The benefits of advance care planning for people living with serious illness seem obvious: a greater sense of control over their medical experience, medical care aligned with their values, reduction of the burden of uncertainty felt by loved ones when care decisions must be made. Yet for many, the prospect of preparing in advance for future medical situations and decisions is fraught with misgivings and hesitation.

Motivational interviewing (MI) is a person-centered and goal-oriented counseling style for strengthening a person's own motivation and commitment to change. With demonstrated efficacy in hundreds of clinical trials and process research identifying the sources of its effectiveness, MI provides an evidence-based model for helping people resolve ambivalence about taking steps that are in their own interest.

MI serves as the foundation of the Living Well Program (LWP), a person-centered model for facilitating ACP conversations with people with serious illness. Over the course of 3-5 telephone conversations, the LWP helps clients to develop, document, and share an advance care plan by exploring their quality of life values, clarifying the factors that shape their medical decisions and goals of care in various "what if...?" scenarios, and partnering with them to communicate their preferences and priorities to family members and healthcare providers through conversations and advance directives. In this presentation, Dr. Zuckoff will describe how MI conceptualizes ambivalence about ACP and how MI can be used by practitioners in a variety of settings to enhance engagement in ACP by people with serious illness.

4. Serious Illness Conversations

Shared Decision Making: What Is It and Why Is It Different in Serious Illness?

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

Outcomes:

1. Explore the current national definitions and recommendations for shared decision making (SDM) as a standard of care for all patients.

2. Examine what is unique about the decision-making process for individuals with serious illness
3. Describe the specific approach required for clinicians to support person-centered decision-making for individuals with serious illness

Abstract Description:

National recommendations call for the adoption of shared decision-making (SDM) as a standard of care for all patients and recognize it as critical to improving person-centered care. However, historic use of SDM has been centered around “medical conditions for which the *clinical evidence* does not clearly support one treatment option, and the appropriate course of treatment depends on the values or preferences of the patient.” This approach focuses on the provision of medical evidence about reasonable alternatives, and then aligning that with patients’ goals, values and preferences for health care as a last step. It infers that each party has only one part to play: the doctor contributes medical information and the patient contributes their goals and values to reach a decision.

This presentation will focus on the unique person-centered decision-making needs of individuals with serious illness— regardless of the disease state or decision being made. Discerning an individual’s goals values and preferences is a pre-requisite to SDM in the context of serious illness. This requires that providers play a role beyond presenting of unbiased clinical information; they must also develop the skills to assist patients in discerning their goals/values/beliefs and the skills to help integrate those preferences into the decision-making process.

Implementation of Next Steps—One Step at a Time Leads to the Next Step

Bridget A. Darden, MAOM, BSN, RN, Life Care Planning, Next Steps and Advanced Steps Faculty, Kaiser Permanente Colorado; Nancy L. Greenstreet, MSW, LCSW, Supportive Care Program Specialist, Kaiser Permanente Colorado

Outcomes:

1. Identify two implementation strategies to successfully initiate and disseminate the Respecting Choices Next Steps ACP program
2. Describe the leadership strategies required for successful implementation of the Next Steps ACP program

Abstract Description:

At Kaiser Permanente Colorado (KPCO) Life Care Planning (LCP) Next Steps (NS) was the last step to be implemented in the LCP program. The implementation process for First Wave of NS was a learning journey. We took baby steps, falling, getting back up, applying the lessons learned, and trying again to move forward with a successful implementation of the NS program.

NS is essential in developing an individual care plan for those experiencing complications with a chronic illness as it allows for an intentional conversation that dives deep into the what ifs of a “bad outcome” (as defined by the individual) due to a complication. This empowers the healthcare agent and healthcare team to be able to provide the care expressed by the individual as well as participate in ongoing shared decision making. Rijken, et. al. demonstrated the importance of individual care plans (ICP)s, “During the last decade, individual care plans (ICPs) have been introduced in healthcare in many countries. ICPs are used in different settings and for different purposes. In chronic illness care, ICPs are implemented to improve patient-centeredness, i.e. to ensure that decision-making about treatment and care and the actual delivery of care is based on patients’ self-assessed needs and personal goals and is tailored to their preferences and competencies. (IJIC, 12/16).

This presentation will describe the implementation of the NS ACP program, including target population, tools, methodology, and outcomes achieved. The presenters, both NS Organization Faculty, will identify the lessons learned along the implementation journey.

5. Workforce Development and Interprofessional Practice

Advancing ACP Education in Medical Practices Through Collaboration with Physicians

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

Outcomes:

1. Identify at least one strategy where collaborative efforts between organizations can be influential in establishing a stronger presence of trained person-centered ACP facilitator resources.
2. Describe how a trained First Steps ACP Instructor engages with community stakeholders to have a multiplier effect of training many creating increased access to ACP information and person-centered ACP resources in the community.

Abstract Description:

Person-centered Advance Care Planning (ACP), a process to assist individuals in making informed decisions about future medical care, is gaining ground in New York's Capital Region. This presentation will describe a multimodal approach of providing person-centered ACP training to medical groups, physicians and their clinical teams, and college students. Several strategies will be shared on how a Respecting Choices certified First Steps ACP Instructor engaged key stakeholders to collaborate in providing ACP training and procure grant funding to support program sustainability: 1) engage and strategize with medical office staff to be trained as ACP facilitators and sustain an ongoing process of conversations with patients, 2) establish liaison relationships with hospital systems and home health agencies to increase access to a wider group of patients, 3) prepare grant applications to secure funding for education, training and marketing, and 4) engage college students to complete ACP training to enhance their learning experience. The collaborative nature of these engagement strategies shows promise of increasing awareness and access to person-centered ACP resources and conversations.

The Creation and Use of an ACP Online Curriculum for Physicians and Advanced Practitioners

Linda Briggs, MSN, MA, RN, Associate Director, Respecting Choice; Joyce Smerick, BS, Senior Faculty Consultant, Respecting Choices

Outcomes:

1. Illustrate the need for advance care planning education for physicians and advanced practitioners
2. Apply three strategies for using this curriculum to support an advance care planning program implementation

Abstract Description:

Currently, there are many options for advance care planning (ACP) education for health professionals. Some focus on legal and technical aspects of completing advance directive documents; others focus more on conversations. How these conversations are offered and conducted is not standardized. In this regard, the field of ACP remains fragmented and confusing for

both health professionals and patients alike and physicians still report feeling unprepared to initiate these conversations.

To bring some direction, uniformity, and evidence to the field of ACP conversations, Respecting Choices (with funding from the Gordon and Betty Moore Foundation) created a 3-module, online curriculum to build person-centered ACP skills of physicians and advanced practitioners. The goal of the curriculum is to assist physicians in identifying practical steps to integrate basic ACP into their everyday practice, especially for patients who have not started the planning process. Modules 1 and 2 provide foundational skills to introduce ACP, motivate patients to participate, and guide and document these essential conversations. Module 3 identifies several key strategies for integrating ACP into the routines of patient care, including ACP billing.

This presentation will describe the ACP education specific to the learning needs for physicians and advanced practitioners; 2) the steps necessary to create and evaluate a highly interactive online format designed to promote critical thinking; and 3) strategies for using the curriculum to support an ACP program implementation.

Closing Plenary Session

Person-Centered Shared Decision-Making, Creating Pathways to Success

Jean R. Slutsky, PA, MSPH, Chief Engagement and Dissemination Officer, Patient-Centered Outcomes Research Institute (PCORI®)

Outcomes:

1. Understand Person-centeredness and how it is integrated into research and decision-making
2. Describe the role of Shared Decision-making to deliver person-centered health care
3. Learn about ways to document the value of Person-centered Decision-making that support long term sustainability.

Abstract Description:

Person-centered Decision-Making has been shown to be successful but has often failed to be effectively integrated into the flow of health care. Shared Decision Making (SDM) tools may vary in quality, and there are limited metrics on which to measure their value. Person-centeredness in research, health care, and decision-making take deliberate focus and attention. This session will outline the integration of person-centeredness in research and decision-making by exploring the role of SDM, the necessary emphasis on how to effectively implement SDM into the flow of health care, and ways to understand and document the value of person-centered decision-making.
