About C-TAC

C-TAC is a coalition of more than 200 organizations that advances policies that deliver the comprehensive care that patients need and deserve. We are transforming a broken and fragmented health system to improve the quality of life for those impacted by serious illness.

Our mission is to ensure support for those experiencing serious illness and for those who care for them by serving as the national advocacy voice and catalyst for an influential network of coalition members, partners, and policy makers.

Our vision is that all persons impacted by serious illness, especially those who are underserved and under-resourced, have a high quality of life – on their own terms.

Advance Care Planning for All

Case Studies for Scaling ACP from Pioneers in the Field

WiserCare

Respecting Choices®
PERSON-CENTERED CARE

PARKVIEW HEALTH

WELLSPAN HEALTH

WiserCare

Arul Thangavel, MD

Chief Executive Officer, WiserCare

The Impact of Advance Care Planning

Enhanced Patient Experience

- Improved family communication with care teams and each other in the last phase of life
- Increased concordance between wishes and care received

Improved Care Team Experience

- Less care team trauma and burnout from delivering unwanted care
- Deeper connections with patients about goals of care

Reduced Total Cost of Care

- 14K lower costs in the last year of life
- Reduced utilization from intensive, unwanted interventions

Despite widespread evidence and support, **only 3% of patients** nationwide have **high quality ACP** conversations.

*References: doi.org/10.37765/ajac.2022.89164; pubmed.ncbi.nlm.nih.gov/29206564/

So Why Isn’t Everyone Doing ACP?

Despite evidence and motivation, barriers still exist

Lack of Training

Workforce Shortage

Competing Priorities

Lack of Access

Individual Resistance

The good news: Winds are shifting and we are beginning to address these barriers as a community through technology, service offerings, policy and education

ACP Should Be a Population Health Intervention

Programs should aim to reach >50% of older adults with high quality, comprehensive ACP

	Projected death rate	High-Touch Approach	High-Low Combination	Low-Touch
Critical Risk Population (2%) (CCI: 5+)	22%	✅		✅
High Risk Population (30%) (CCI: 3-4)	13%		✅	✅
Elevated Risk Population (20%) (CCI: 2)	4%		✅	✅
Average Risk Population (48%) (CCI: 0-1)	<1%			✅

Keeping an Eye on Quality

Documents
- and CPT codes -
are necessary, but
not sufficient

Focus on **supporting high-quality interactions** as you scale

Respecting Choices®
PERSON-CENTERED CARE

Dr. Stephanie Anderson, DNP, RN

Executive Director, C-TAC Innovations

Person-Centered and Family-Oriented Care

The Promises of ACP

Promise 1

Initiate conversations

Promise 2

Provide an assistance with person-centered decision making

Promise 3

Make sure plans are clear

Promise 4

Store, update, and use plans

Promise 5

Honor preferences and decisions

The Value of a Skilled ACP Facilitator

PARKVIEW HEALTH

Chris Brinneman, MSW, LCSW

Advance Care Planning Manager, Parkview Health System

Advance Care Planning: Patient Centered-Care

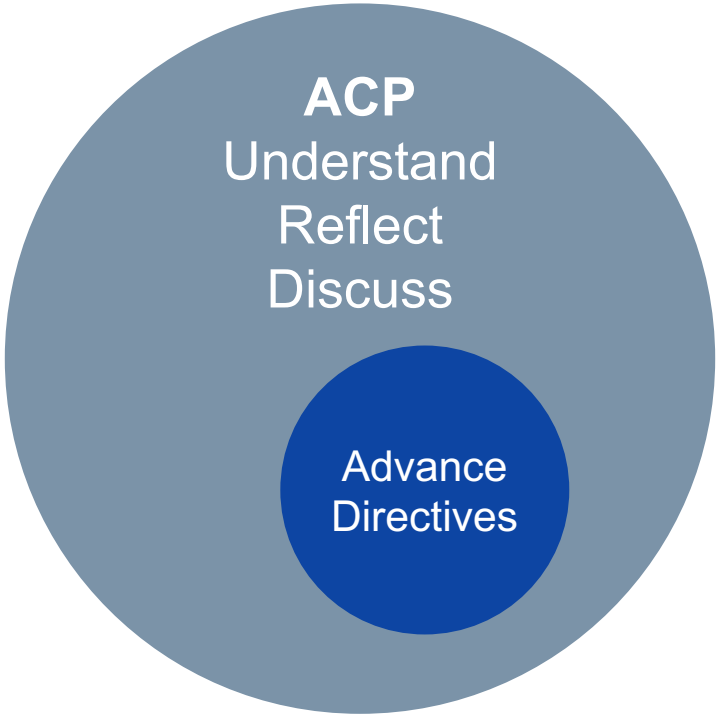
Values

Goals

Preferences

Advance Care Planning (ACP) conversations include reflection and discussion about values, goals, and treatment preferences to help ensure that the plan of care future health care decision making is truly person-centered.

Advance Care Planning and Advance Directives



Background – ACP at Parkview

Historically, prior to implementing ACP at Parkview, only addressed advance directives as mandated by the federal Patient Self-Determination Act or if the patient initiated the conversation.

The Advance Care Planning (ACP) Program at Parkview Health went live on May 15, 2017.

Chose and integrated the Respecting Choices® model of ACP.

Started Small; Thinking Big:

- Initially certified ACP Facilitators in waves (90 within the first 3 waves over 2.5 years).
- Currently have 150+ certified ACP facilitators within the Parkview Health System and surrounding community.
- Intentionally chose teams that would have opportunity to facilitate ACP conversations.

Program Design

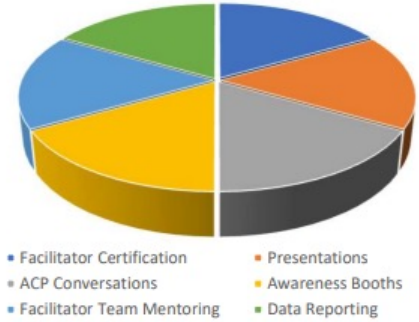
- Parkview Health has as dedicated ACP department with a fulltime manager and two fulltime ACP Specialists. We have paid and nonpaid interns and are working to add a fulltime ACP facilitator.
- Advance Care Planning at Parkview and in our community is designed around an “inviter model” to purposefully extend an invitation to participate in ACP, regardless of age or health.
- We train ACP facilitators using the Respecting Choices model and also have customized training for ACP introducers and ACP inviters.
- We are expecting a “yes” response (goal – 50%) but also track and have follow up plans for those who say “maybe” and those who say “yes”.

Background – ACP at Parkview

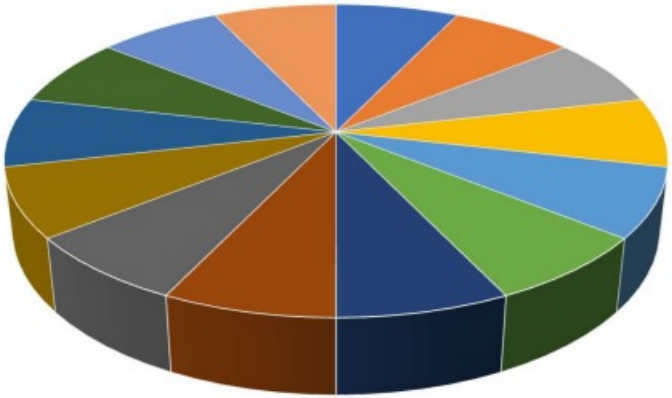
- Break down barriers to an individual's ability, acceptance, and willingness to engage in ACP.
- Have a robust ACP steering committee – from the beginning.
- Have a co-worker initiative from the beginning.
- Flex with the ebb and flow of work groups needed to support system ACP needs:
  - Advance Directive documents
  - Community Engagement
  - Quality
  - EMR documentation/ storage/retrieval
  - Chart correction
  - Nursing education

Growth and Spread of ACP

Then



Now



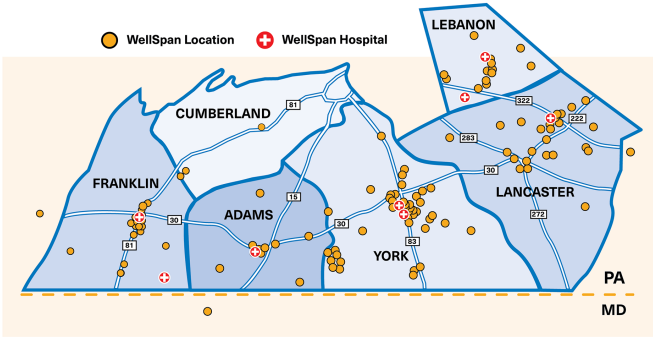
Roberta Geidner

Manager, Horizon/Advance Care Planning,
WellSpan Health

Horizon Planning®
The Importance of a Conversation

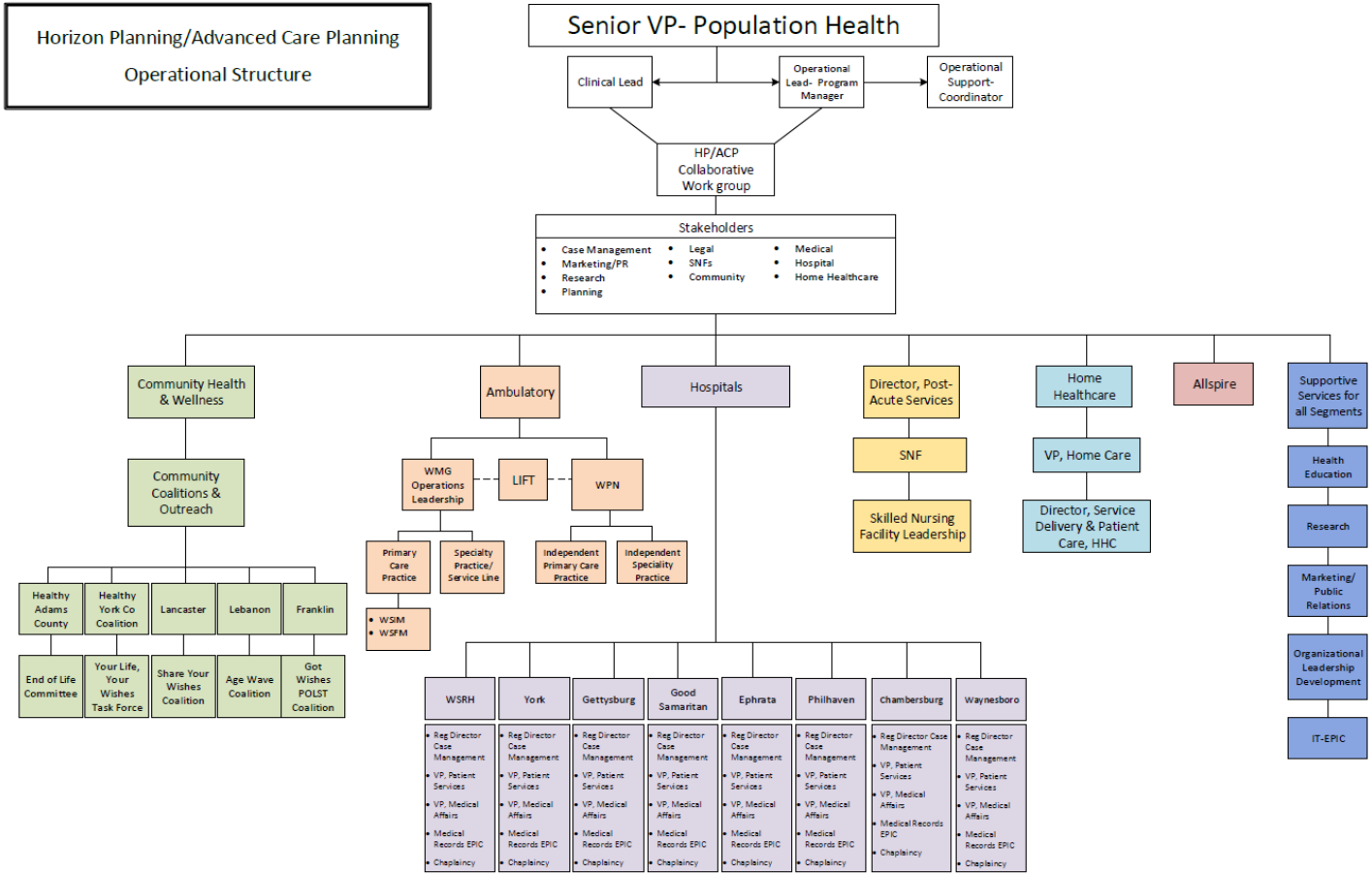

ERIE
CRAWFORD
WARREN
McKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
MERCER
VENANGO
FOREST
ELK
CAMERON
CLINTON
LYCOMING
MONTOUR
SULLIVAN
WYOMING
LACKA-WANNA
PIKE
LAW-RENCE
BUTLER
ARM-STRONG
JEFFER-SON
CLARION
CLEARFIELD
CENTRE
UNION
COLUMBIA
LUZERNE
MONROE
CARBON
BEAVER
INDIANA
CAMBRIA
SNYDER
NORTH-UMBERLAND
SCHUYLKILL
NORTHAMP-TON
LEHIGH
ALLEGHENY
BLAIR
MIFFLIN
JUNIATA
PERRY
DAUPHIN
LEBANON
BERKS
BUCKS
WESTMORELAND
HUNTING-DON
Harrisburg
CUMBER-LAND
LANCASTER
DELAWARE
MONTGOMERY
WASHINGTON
GREENE
FAYETTE
SOMERSET
BEDFORD
FULTON
FRANKLIN
ADAMS
YORK
CHESTER
Philadelphia
PHILADELPHIA


WELLSPAN®
HEALTH


WellSpan Location
WellSpan Hospital
LEBANON
CUMBERLAND
81
322
222
283
30
FRANKLIN
15
ADAMS
90
30
LANCASTER
272
81
83
YORK
PA
MD


York

Horizon Planning/Advanced Care Planning Operational Structure



What Started Our Journey?

PATIENTS ASKED IF THEY HAVE AN ADVANCE DIRECTIVE ON FILE, AND LOTS OF EFFORTS ON GETTING DOCUMENTS

BUT IN 2013 – A SENIOR VP ASKS: WE HAVE BEEN ASKING FOR YEARS BUT WHAT IS WRONG WITH THIS PICTURE?

- High readmission rates & unnecessary treatments
- Changes to palliative care provision
- Participation in population health value based ACOs
- Cost containment impact
- Not meeting quadruple aim

Our Horizon Planning® Journey

Leadership buy in and support

FY14	FY15	FY16	FY17	FY18
Preparation for system-wide effort	Preparation for pilot projects	Pilot Project Launched	Expansion to new sites	Scale to multiple sites and entities across the continuum
	Blue Book Objective met: 95% of Physicians trained in advance care planning concepts	**Blue Book Objective met:** Successful pilot in 3 WMG Practices	**Blue Book Objective met:** 10 WMG Practices **Blue Book Objective met:** 1313 Horizon Plans Completed (Target of 1000)	**Blue Book Objective: EPIC** as source of truth – Horizon Plan and Advance Directives
• Horizon Planning Collaborative Group	• LMS Training Module Completed • **AllSpire** Board Resolution from ACP Committee. • Healthy York County and Healthy Adams County Coalitions – Advance Care Planning Task Forces	• Workflow created • Patient tools • Staff training tools • **AllSpire** organizational structure to operationalize Board Resolution • County Coalitions continue and expand outreach	• Infrastructure: addition of HP/ACP coordinator • **AllSpire** Your Life Your Wishes website launch • Community Health & Wellness begins community outreach efforts • York and Adams Ctys continue outreach	• System-wide Sites • Collaborative Group ➢ Vision Statement ➢ Strategic Plan • Training in *Respecting Choices*® model • **AllSpire Project:** Employee Engagement with *Hello Game*® • Creation of Horizon Planning Report for accountability

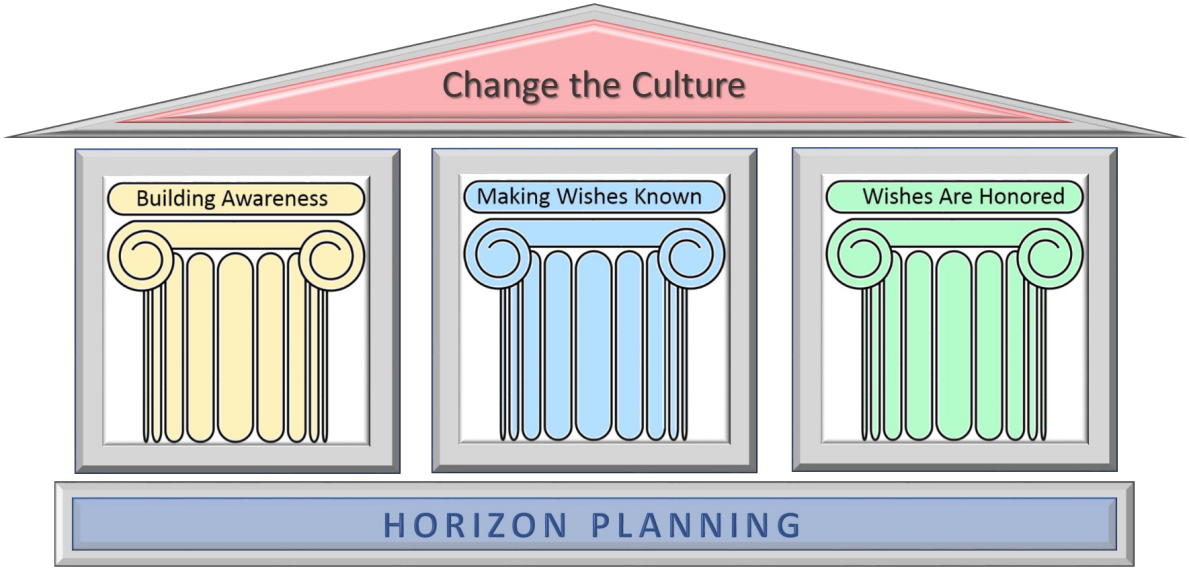
Horizon Planning Vision and Strategies

WellSpan's Vision:

An empowered community that discusses death openly across all ages and backgrounds.

Conversations about dying are not feared and avoided but cherished. Each individual's wishes are known, respected and honored so people live and die with dignity.

Key Strategies:



Our Horizon Planning® Journey

Leadership buy in and support

FY19	FY20	FY21	FY22	FY23
Scale to multiple sites and entities across the system	Respond to COVID-19 with innovative response	Create team of Certified Facilitators	Expand Horizon Planning Team with regional reps	Add AWV & Home Health Nursing Teams
Blue Book Objective met: Discussion in December re: AllSpire Project	**Blue Book Objective:** **Pause with new CEO**	**Blue Book Objective: Deliver: END OF LIFE** Support patients at end-of-life by standardizing processes which improve quality and experience, and by addressing needs of diverse populations. COVID-19 prioritization.	**Quality Improvement Measure:** Part of our Health System DNA	**Need for Better Access:** Explore Digital Solutions for patient access to Five Wishes and Conversations
• Scalability • Training Facilitators • Creating Employee Champions • Create LMS training program for all staff	* Created Horizon Planning Response Team with 35 furloughed staff * Instituted Care Companion App from EPIC – 280 patients * Over 2000 high risk patients reached in 3 mos * Added 1 FTE to HP Team	* Trained 65 Certified Facilitators in Respecting Choices First Steps. * Horizon Planning Coordinator & Manager Certified Instructors in First & Next Steps. * Expanded virtual community education efforts through coalitions * First Employee Required Annual Training	• Additional LMS training courses • Improved EPIC documentation tools • Added 2 FTE to Horizon Planning Team = 4 FTE • HP Staff trained in Advance Steps as facilitators and instructors	Documented 37,130 conversations. Goal of 48,000 for FY24.

What are the goals of Horizon Planning?

Ensure **conversations** about an individual's preferences and hopes are happening **early** and **often** in conjunction with a care provider.

Ensure a **standard approach** to having these conversations.

Include the patient's **family and those important to them** in these discussions.

Create a **care** experience for patients that is **well planned**.

Diminish or reduce the **moral distress experienced by family** who must make healthcare decision when they do not know what the patient would want.

Diminish or reduce the **moral distress experienced health care staff.**

Why do it differently?

	Before → Now	
Approach	Siloed Approach	Systems Approach
Structure	Limited structure Individual bright spots	Structured process Bright spots throughout system
Responsibility	Physician/APC responsibility	Team process with shared responsibility
Process	Static	Dynamic Process which takes place over time
Focus	Documentation	Conversations with multiple parties – Family, Proxy, Health Care team
Tools And Training	Limited Tools and Training	Enhanced tools and training
Culture	Focused on numbers on file and not on follow up and use. Results are increased conflict at end of life, moral distress for health care staff, and high cost of unnecessary treatment.	Focused on outcome of conversation and wishes honored. Reduces moral distress, less anxiety and depression for families, and higher use of palliative /hospice care.

Creating a Horizon Plan is a three-step process … Decide, Discuss, Document

- Team/System approach
- Emphasis on conversation
- Help patients think through
- Multi-step process
- Extent of conversation is different based on staff/provider role and patient's phase of life

Horizon Planning® Workflow for WellSpan Hospitals

UPON HOSPITAL ADMISSION

ADMITTING NURSE

- Looks at previous ACP notes for patient to review any history through Snapshot/Plan of Care.
- Answers questions in Admission Navigator on Advance Care Planning. Provides packet of information on Horizon Planning if patient requests information.
- Sends BPA Consult to Case Mgt for Follow Up if patient has requested information or to update Advance Directives.

CASE MANAGEMENT

- Answers general questions and provides Horizon Planning packet. Request copy of Advance Directives if appropriate.
- Completes Horizon Plan®/Advance Care Planning Note in Epic using Smart Phrase.
- Secure Chat message handoff to attending physician and nursing pool to address Horizon Planning with patients at discharge.
- Sends consult to Spiritual Care as requested by the patient.
- Coordinates discussion with Palliative Care as appropriate.

VISIT DAY BEFORE OR DAY OF DISCHARGE

ATTENDING PHYSICIAN/HOSPITALIST

- Makes this a standard conversation on discharge.
- Looks at previous ACP notes for patient to review any history through Advance Directive icon in Storyboard, and then ACP Notes.
- To find patient's Advance Directives on file, clicks on Advance Directives icon in Storyboard (has acp docs), or Media & Horizon Planning filter.
- At discharge, discusses Horizon Planning®. Encourages patient to review materials and discuss with family and PCP.
- Documents conversation with patient. Create ACP note in Discharge Summary. Use **Smart Phrase ".acpdiscussion"**, Use template to capture your conversation with patient. **Embed Smart Phrase in note template using Speed Button option.**
- Encourages follow-up with patient's PCP. Answer any questions about health condition and possible End-of-Life treatment options if appropriate.

DAY OF DISCHARGE

DISCHARGE NURSE

- Looks at previous ACP notes for patient to review any history through Advance Directive icon in Storyboard.
- Reinforces need and value of Advance Care Planning conversations.
- Completes Advance Care Planning questions in Epic Discharge Summary and notes patient's interest in Horizon Planning.
- Requests patient complete and return the Five Wishes® booklet to PCP or Medical Records at Hospital.
- Gives patient Conversation Starter Guide® if has Living Will but has not discussed with family/loved ones.
- Ensures patient has all original POLST, any VOIDED POLST forms and original Advance Directives at discharge if applicable.

DURING HOSPITAL STAY

PATIENT PROVIDES THE FIVE WISHES® BOOKLET, POLST OR OTHER ADVANCE DIRECTIVES

- Copy of Advance Directives or POLST will be placed in bin for scanning by Medical Records.
- Follow workflow for scanning Advance Directives.
  - Label every page
  - Scan twice if both Living Will and Power of Attorney for Healthcare is in document
  - Change date scanned to date signed and note date signed in description field.
- All original documents returned to patient on discharge.

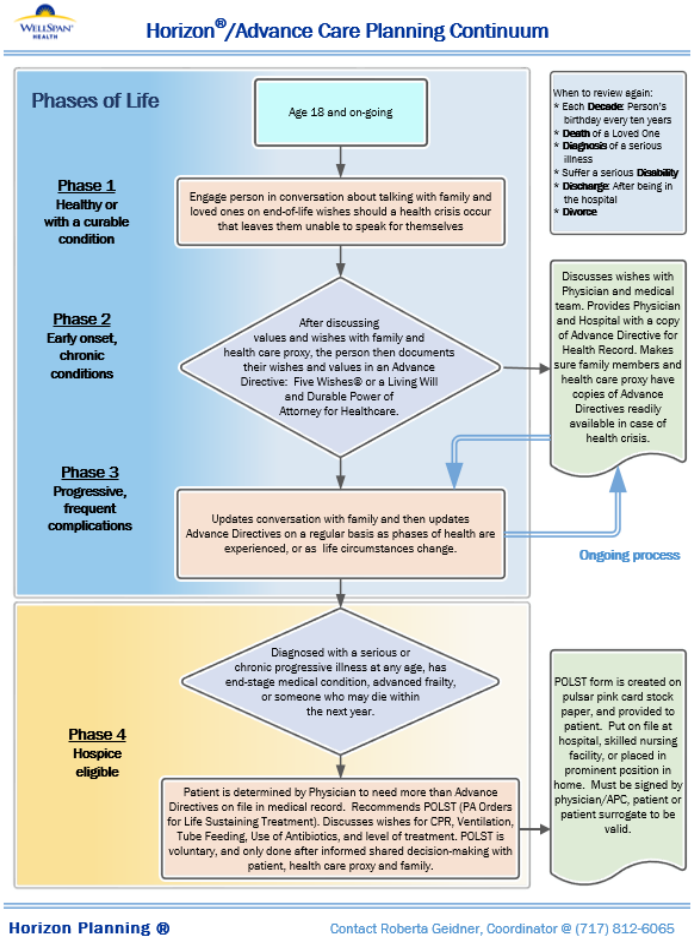
Once the Horizon Planning® Note is complete, it is considered that you have completed this portion of the Horizon Plan®. Advise patient of information in My WellSpan portal on Horizon Planning or through wellspan.org/horizonplanning.

08/27/2022 RG

Horizon Planning® tools

For Staff:

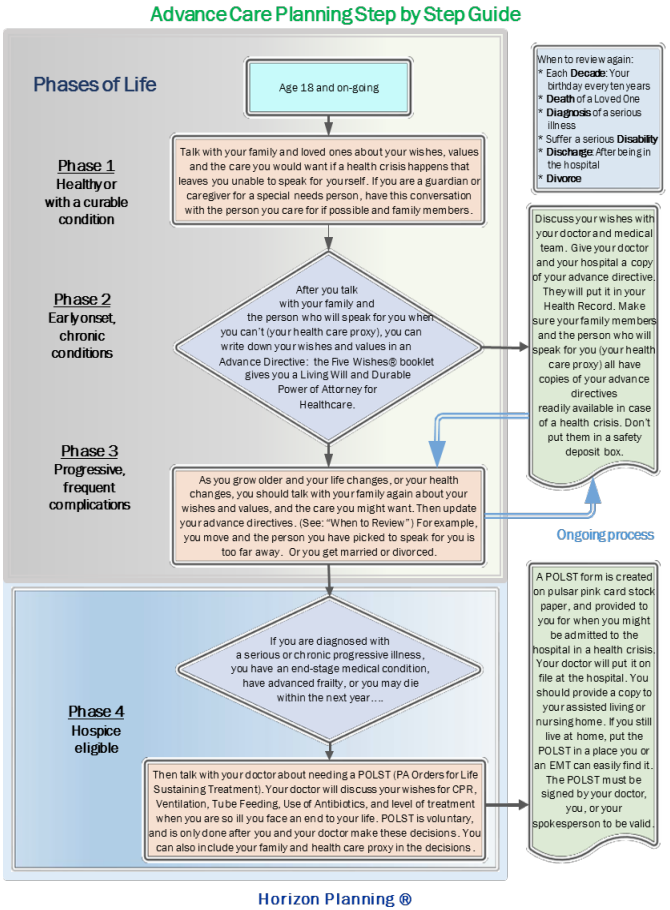
- Horizon®/Advance Care Planning Continuum
- Horizon Planning Scripting
- Advance Care Planning Assessment Guide
- Horizon Planning® Documents Review Guide
- Horizon Planning® Workflows
- Horizon Planning® LMS Training Module
- Phases of Life Conversation Card
- Five Wishes® Conversation Guide for Clinicians



Horizon Planning® tools

For Patients (both English and Spanish):

- Horizon Planning® brochure
- Horizon Planning® Patient Instructions
- Advance Care Planning Step by Step Guide
- Legal Documents All Adults Should Have
- Five Wishes® booklet
- End of Life Treatments Education Guides
- Making Choices – Health Care Agent Responsibilities
- The Conversation Starter Guide®
- The POLST kit – Brochure, Form, Wallet Card



Documenting and Scanning into Epic

1

Documentation guidance to ensure all items are documented to the Advance Care Planning Page in EPIC.

2

ACP Activity page will provide each role with ACP notes or assessments from previous conversations within the health system. No conversation will be lost in Notes section of Chart.

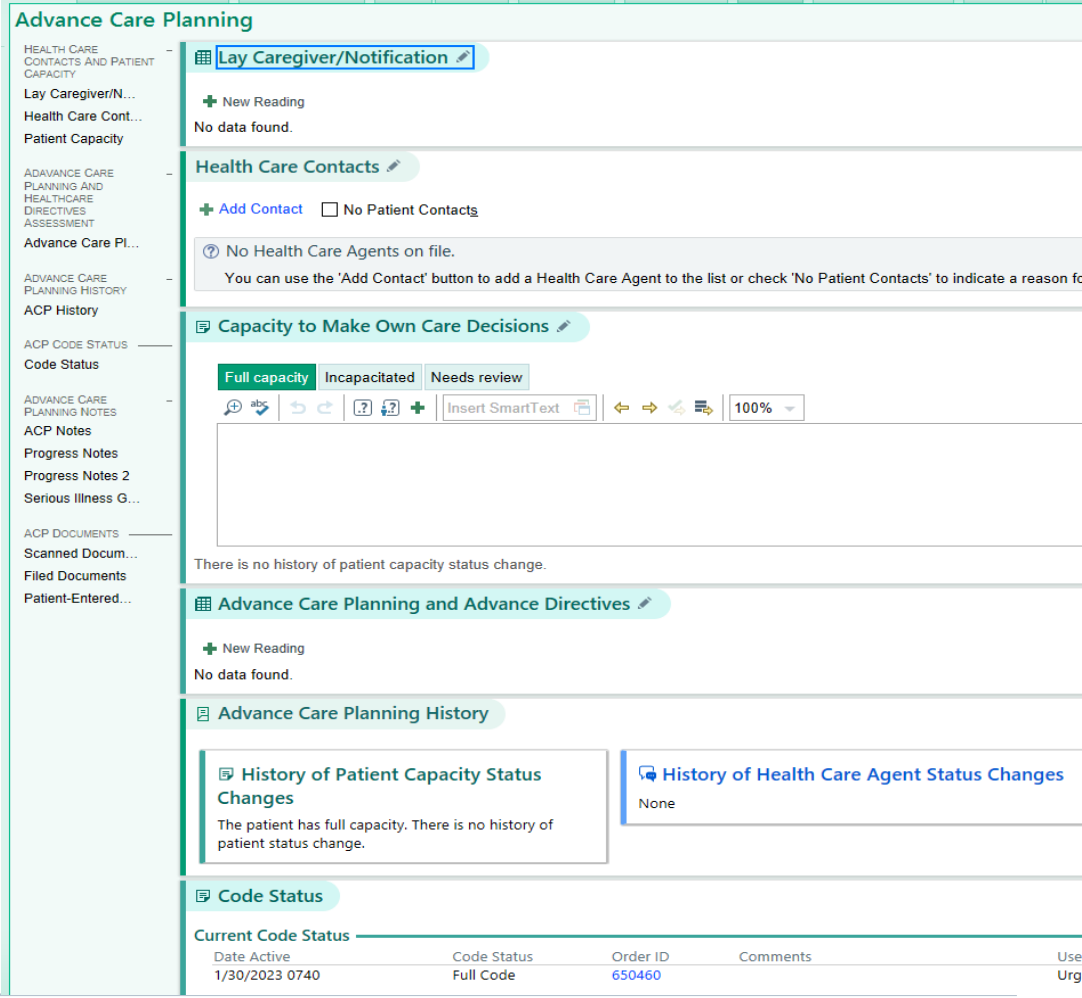
3

Scanning will be done by Medical Records with copies of documents, so originals stay with patients upon discharge. Too many key documents are lost so adding Advance Directives & POLST to Personal Belongings List.

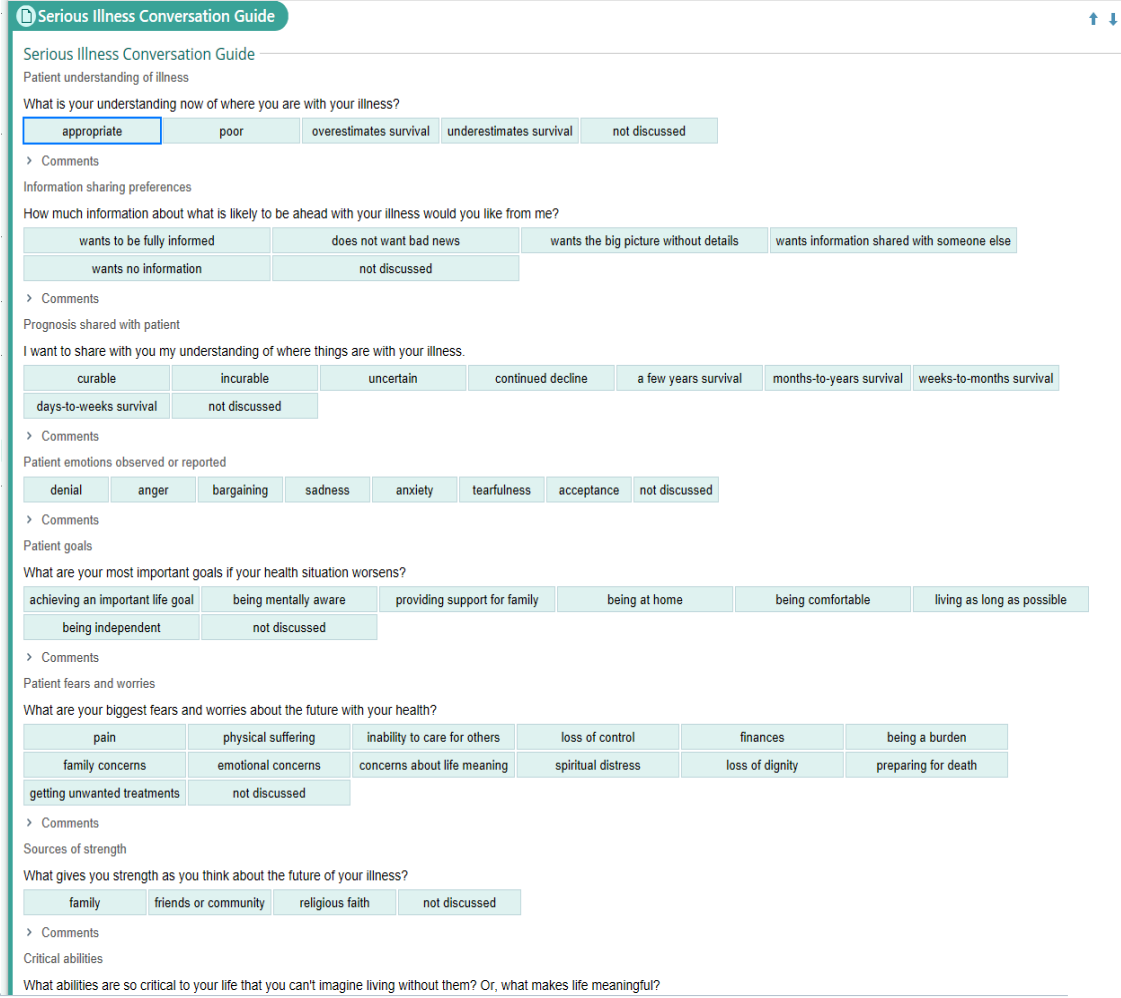
Updated by Ambulatory Informatics Team: 1/25/2022

Horizon Planning – ACP Documentation Guide

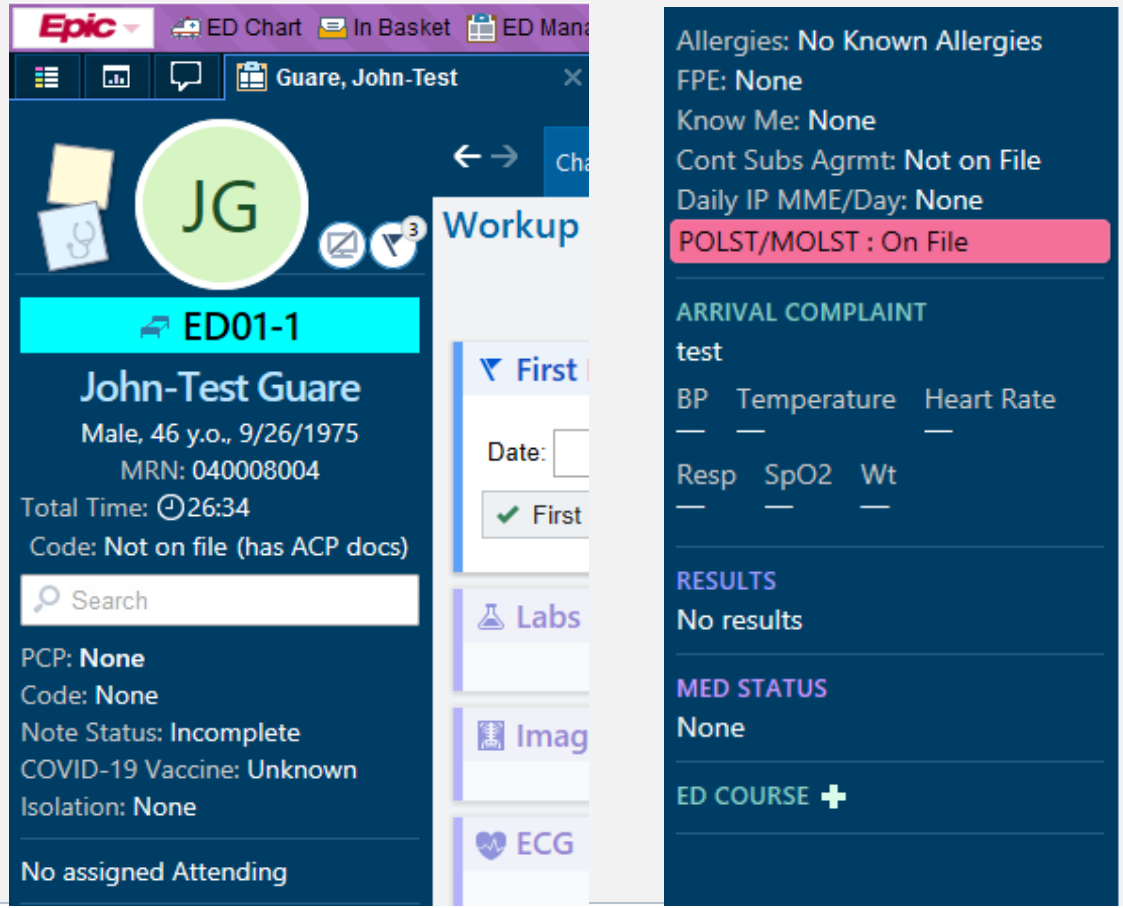
ACP Page is Designed to be the Source of Truth in Epic.



Serious Illness Guide on ACP Activity Page to Support Conversations



Storyboard if POLST/MOLST Exists:

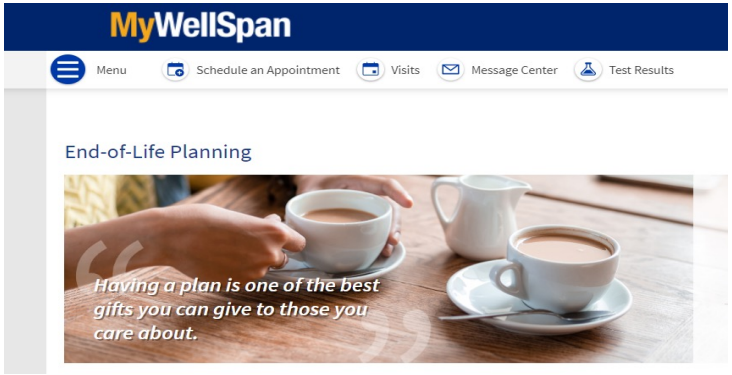


WellSpan Resources

Horizon Planning on WellSpan.org:
wellspan.org/patients-visitors/patient-guide/horizon-planning/

Info and ordering a Horizon Planning Packet available here.

MyWellSpan Portal
Ability to upload documents and ordering Horizon Planning packets available here.



Goal concordant care impacts TCOC and Patient Experience = Being a Trusted Partner

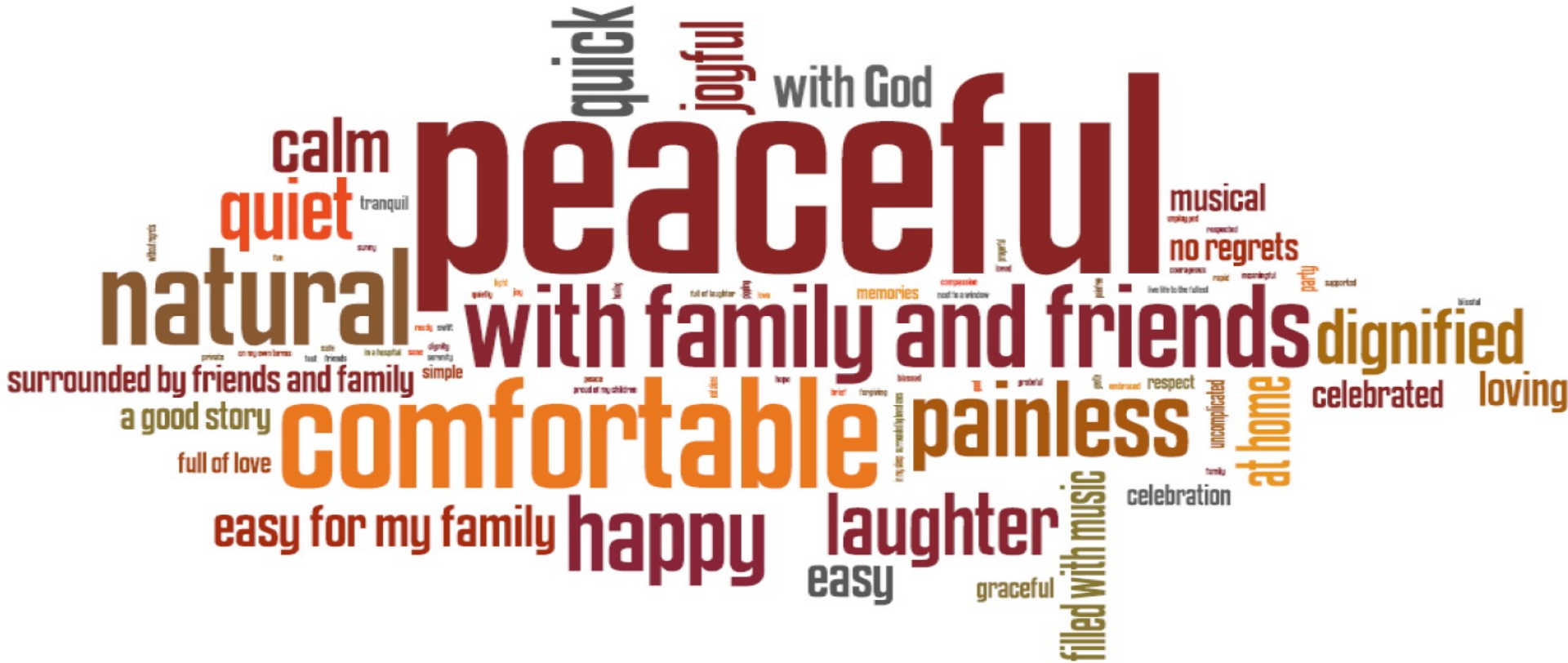
Research demonstrates that by achieving goal concordant care, health systems increase the quality of life for people while using fewer resources, all with quality care:

- Fewer days in the hospital
- Fewer days in an ICU
- More days in a place that supports their wishes
- Better support from palliative and hospice care resources
- Making person centered, shared decision-making care our priority
- Reduced total cost of care by 25% or between $6,000 - $23,000 per patient depending on stay in an ICU

Reference: WSH NEJM Catalyst article published August 2022 – Research on COVID patients with and without Advance Directives who died of COVID 2021

What will we accomplish by changing the culture?

- Improve your relationship with your patient by discussing care wishes
- Decrease the moral distress of staff and providers by knowing exactly what a patient's wishes are for end-of-life care
- Improve your patient's experience with illness progression and end-of-life care
- Enable family members and loved ones to navigate and grieve with less anxiety, depression, and stress


peaceful
natural
with family and friends
comfortable
painless
happy
laughter
easy
quick
joyful
with God
calm
quiet
tranquil
musical
no regrets
dignified
surrounded by friends and family
simple
a good story
full of love
easy for my family
celebrated
loving
respect
at home
uncomplicated
celebration
filled with music
graceful
memories

Better Together: WiserCare + Respecting Choices

Better Together: WiserCare and Respecting Choices

We are now one company!

WiserCare and Respecting Choices have worked together for several years with the shared goal of helping organizations expand access to ACP in a resource-efficient way. We deliver RC-aligned content digitally, while maintaining high-quality conversations.

WiserCare is committed to preserving – and growing – Respecting Choices' suite of training, implementation and capacity-building services to help achieve the scale we need to make high quality ACP for all – and the benefits it conveys - a reality!

WiserCare's Deeply Experienced Facilitator Pool

Respecting Choices®
PERSON-CENTERED CARE

WiserCare ACP facilitator network is highly skilled and experienced in difficult ACP conversations

Facilitators are:

Trained and experienced in all stages of ACP conversations, from basic conversations to intensive conversations for seriously ill / high risk individuals

Routinely gather ACP-adjacent information to inform ongoing clinical care

Ready and able to perform telephonic or video ACP facilitation sessions

Use WiserCare's platform to digitally document ACP conversations, generate insights for your physicians and complete state- or institution-specific documents

WiserCare's Approach to Scalable ACP

Digital Self-Service ACP for Low-Risk

- Deeply engaging, best-in-class ACP patient experience
- Focus on values and preferences
- Respecting Choices-aligned
- Document execution and storage

Enable High-Quality, Provider-Led ACP

- Allows providers to review patient ACP data, document ACP conversations and take next steps in care
- Condition-specific content
- POLST / POST / MOST support

Increase capacity through Tele-ACP

- Conversation support from experienced, trained specialists
- Conversations are efficient - pick up from digital experience
- Best-in-class ACP training if using a bring-your-own model

Engage stakeholders

- Health care decision maker
- Family members

Q&A

C+TAC

C-TAC | CAPC Leadership Summit

October 23 – 24, 2023
Washington, DC

December Policy Meet-Up

Wednesday, December 6, 2023
Via Zoom

For more information on membership:

Contact Luke Scuitto at lscuitto@thectac.org, Partnerships Director or Sandra Arias sarias@thectac.org, Partnership Associate