Advance Care Planning Collaboration 101

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Overview

• Defining the **process** of Advance Care Planning (ACP)
• Why is ACP important?
• How WE fail our patients
• Fostering Change
• Collaboration
Definition:
Advance Care Planning

A process of reflection, goal setting, and determination of desired future medical decisions.
Why is advance care planning important?

• One in four of us, in this room, will need someone to make end-of-life decisions about our medical care.

• Medicare spent $50 million dollars on the last 6 months of life

• Patients w/ end-of-life discussions preferred medical treatment focused on relieving pain & discomfort over life-extending therapies. NEJM, April 1, 2010

• Those with advance directives often receive less aggressive treatment when death is near. JAMA, Aug. 2008, Vol. 300,

• Patients with advance directives are much less likely to die in the hospital. JAMA, Nov 9, 2011.
MI End of Life Data: Medicare Beneficiaries 2011
During the last 6 months of life

- 71% of the patients had at least one ED visit
- 65% of patients admitted to an inpatient stay at least once
- 34% of patients were readmitted within 30-days of discharge
- 47% of terminal hospitalizations included an ICU admission

- $17,285 is the average inpatient spending per patient
- $26,541 is the average spending among those that had an inpatient admission
- $19,414 inpatient average spending on terminal hospitalizations

Kaiser Family Foundation: January 14, 2015
How WE fail our patients

• WE make decisions that are only disease centered; thus, we lose focus of the individual

• WE fail to communicate from one care setting to another

• WE don’t have on-going conversations

• WE don’t foster updating plans over time

• WE force decisions into “boxes” by construing choices as either treating the disease or focusing on comfort
WE can foster change

• WE can encourage advance care planning sooner
• WE can share communicate from one care setting to another
• WE can add advance care planning to routine physicals
• WE can collaborate to create a productive process, reduce repetition, and foster culture change
Shocking Statics?

• Statics indicate: 100% - We are all going to die.

• Statics indicate: 100% - We will all face death of a loved one at some point during our lifetime.

• We spend a lot of time and effort on treatments with much lower statics.
Missed opportunities

• Studies reveal the impact of life limiting illnesses and potentially avoidable hospitalizations
  
  o Life Limiting illnesses
    o CHF
      • estimated over 1 million hospitalizations each year
      • CHF often causes other co-morbidities (HTN, DM, CAD)
    o Cancer
    o COPD
    o Diabetes
    o Alcohol/Drug Addiction

National Center for Health Statistics: https://www.cdc.gov/nchs/products/databriefs/db108.htm
WE can foster change

• WE can encourage earlier conversations
  o Not just at end of life
  o Not only when there is a significant diagnosis
  o Not only for the elderly
  o Should start talking about death at a young age
    • Loss of a pet
    • Stomping a bug
    • Grandma/grandpa dies
WE can foster change

• WE can add advance care planning to routine physicals
  o Provide training on how to incorporate ACP into primary care
  o Making this a standard for annual visits

• WE need to be honest with our patients
  o Planning for a good death requires knowing that one is dying.
  o Perceptions vary significantly (see next slide)
Loved Ones Expectations vrs. Physician Expectations


*1 yr estimation after trach placement

- **Physician**
  - Be Alive: 43%
  - Live Independently: 6%
  - Have Good Quality of Life: 83%

- **Loved Ones**
  - Be Alive: 93%
  - Live Independently: 71%
  - Have Good Quality of Life: 83%

43% 6% 4%
WE can foster change

- WE can share communicate from one care setting to another
  - Set up systems for sharing healthcare decision making documents
  - Create standardized language
WE can foster change

• WE can collaborate to create a more productive process
• Know your role in this process
  o Identify ways to reduce repetitive work
Collaboration!!!

Primary Care, Home Care, Hospice, Palliative Care, Acute Care, ECF, SNF, AFC....etc
Enhancing ACP

- Training ACP facilitators in primary care settings
- Create group settings/workshops
- Create referral process with local agencies or your local hospitals advance care planning department.
- Encourage ACP at discharge from hospitalization
ACP goals

• Normalize ACP
  o We do this w/ all our patients at intake because we know that we can’t honor your wishes if we don’t know what they are.
  o This is part of a new initiative to make sure we keep you and your wishes at the center of the care we deliver to you

• ACP, by definition, must be patient centric, not clinician driven.

• Requires
  o Understanding
  o Reflection
  o Discussion

• Encouragement through multiple conversations
Let's Review

- The **process** of Advance Care Planning (ACP)
- Why is ACP important?
- Fostering Change
- Collaboration

*What's next?*

*The second conversation........*
Step by Step process for ACP in primary care
Initial Meeting:

1. Assess motivation, knowledge and beliefs related to ACP
2. Identify understanding of ACP and AMD’s.
3. Explore understanding of chronic illness
4. Explore past experiences
5. Explore what “living well” means
6. Explore cultural, religious, spiritual, or personal beliefs
7. Explore potential healthcare agent(s)
8. Provide a summary and follow-up
Step 1: Assessing Motivation, Knowledge, & Beliefs

• “Can you tell me what you understanding about advance care planning?”

• Defining:
  
  o **ACP:** “This is planning for all adults. It is thinking about future healthcare decision if you had a sudden event, like a car accident or illness, and could not make your own decisions. This planning will help you and the person you choose understand your goals and values for living well. “

  o **AMD:** “it’s important to write down your goals, values, and preferences. This is called an advance directive, and it allows you to choose a person who can make healthcare decisions for you. This person ONLY makes decisions if you cannot make them for yourself.”
Step 2: Identify understanding of ACP & AMDs

- “What conversations have you had about possible medical treatments with your family or loved ones?”
- “What fears or concerns do you have about planning?”
- “What do you hope an AMD will do for you in the future?”
Step 3: Explore understanding of illness

- “Tell me what you understand about your illness.”
- “Have there been any changes with your illness in the past few months?”
- “What problems do you think you may have in the future from your illness?”
Step 4: Explore past experiences

- “Tell me briefly about any experiences you have had with family or friends who became seriously ill or injured (like a car accident or grandparents).”
  - “What did you learn from that experience?”

- “Have you been in the hospital recently because of your illness?”
  - “What did you learn from that experience?”

- “Are there any other experiences you’ve had related to medical care?”
Step 5: Explore what “living well” means

• “What does “living well” mean to you?”
• “If you were having a good day, what would be happening on that day?”
• “What are some things you really enjoy doing?”
• “What worries you most about your illness?”
• “What fears do you have about your illness?”
• “Who or what helps you when you face serious challenges in life?”
Step 6: Explore unique cultural, religious, spiritual, or personal beliefs

• “What cultural, religious, spiritual, or personal beliefs do you have that might help you choose the care you would want, or would not want?”

• “Are there cultural, religious, or spiritual practices that are important to you or give you comfort, such as praying, singing, or eating certain foods?”

• “Would you like to talk to someone about these beliefs or concerns?”
Step 7: Explore potential healthcare agent

- “One of the most important decisions we encourage people to make is choosing someone you trust to make healthcare decisions for you. This person would only make decisions if you had a sudden event and could not make your own decisions.”

- “I’d like you to imagine a scenario: a sudden event like a car accident or an illness that left you unable to communicate. Who would you choose to be your healthcare decision maker?”
Step 7 (cont): Explore potential healthcare agent

• “It is important to think carefully about his decision. There are four qualities you should look for. A healthcare agent should be willing to:
  
  o Accepts the responsibility this role entails,
  o Talk about your goals, values, and preferences,
  o Follow your decision (even if he or she does not agree with them), and
  o Make decisions in difficult moments that reflect your wishes

• “How will you explain the role of healthcare agent when you talk to your chosen person?”
Step 7:
Explore healthy adult decision

- “What would you tell your healthcare agent to do on your behalf if you suddenly, as a result of an unexpected accident, found yourself permanently unable to know who you are, where you are or who is coming to visit you?”
Step 8: Provide a summary to the patient

- To prepare the patient to go home with a blank or partially completed AMD, complete a summary sheet that reminds them of the significant ground covered in conversation. (see handout)
- Schedule a follow up meeting to include their healthcare agent and their draft document.

Next ACP session topics:
- Patients understanding of current health status & their chronic illness
- Introduce informed decision making about CPR status
What’s next...

• Keep the conversation going

**Next ACP session topics:**

• Assess patients on going understanding of current health status & their chronic illness
• Make recommendations for future care based on patient goals
  • Start with goals, NOT interventions.
• Introduce informed decision making about CPR status