Community-Wide Advance Care Planning

Jane Dohrmann, LISW, ACHP-SW
Director, Honoring Your Wishes
Iowa City Hospice, Iowa City

Learning Objectives

• Outline the use of Respecting Choices® First Steps as a model for advance care planning
• Describe successes, barriers and themes in HYW advance care planning pilot studies
• Identify leadership roles of hospice and palliative care providers in collaborating with members of the community to promote advance care planning
What is Advance Care Planning?

• A process to reflect upon one’s values, beliefs, and goals for future healthcare preferences relevant to a person’s stage of illness
• An advance care plan is created (e.g. an advance directive) that reflects a person’s healthcare preferences
• A well prepared healthcare agent & alternate health care agent are engaged in the process
• Plans are communicated to healthcare systems & reviewed regularly

Honoring Your Wishes

• Iowa City Hospice provided leadership for the Initiative in the fall of 2010
• Community stakeholders were invited to form a Steering Committee which met for the first time in Dec. 2010
• Model is based on Respecting Choices®, Gundersen Lutheran Foundation, La Crosse, WI
• A healthcare systems & community approach
• Based upon the principles of:
  – self-determination/co-determination
  – informed consent
  – dignity and worth of the individual
  – empowerment
• Process throughout the life span

Mission
• To sustain an integrated, community-wide planning process where individual future health care preferences are discussed, documented, and honored by families, friends, and the health care community.
Vision

- The advance care planning process will be the standard for health care providers and the community to ensure that every adult’s health care choices are clearly defined and honored.

Respecting Choices®

First Steps (for healthy adults & initial conversations with people affected by chronic illness). This includes:
- introducing Advance Care Planning as a process,
- assisting in the selection of a qualified healthcare agent,
- preparing & empowering the healthcare agent,
- exploring a person’s goals for life-sustaining treatment in the event of a severe neurologic illness where a full cognitive recovery is unlikely, and
- completing an advance directive.

(Briggs, Linda, Chapter 3, Helping Individuals Make Informed Healthcare Decisions: Role of the ACP Facilitator, Having Your Own Say, p. 33)
Respecting Choices®

• Next Steps (disease-specific planning for people with a chronic progressive illness) and
• Last Steps (for people who are terminally ill, the frail, and elderly). This includes assisting individuals in clarifying goals of care and making treatment decisions/IPOST.

Honoring Your Wishes

Respecting Choices®

• www.respectingchoices.org
• An evidence-based advance care planning model
• Fully implemented in 1993
• Collaboration between healthcare organizations and the community
• Adults with decision-making capacity are provided competent assistance by trained facilitators in the planning process
Respecting Choices®

- Adults are invited to discuss plans for future health care relevant to their stage of illness
- Written plans are created & understood by stakeholders
- Written plans are stored, transferred, & retrievable
- Plans are updated, reviewed & honored  
  (Hammes, et al, 2010)

Key Components to a Successful ACP System

- Building an ACP infrastructure (training of healthcare professionals, documenting ACP discussions and having accessible records)
- AD document that reflects a person’s goals, values, and beliefs
- Certified ACP facilitators
- Community Engagement
- Continuous quality improvement  
  (Hammes B & Briggs L, Building a Systems Approach to Advance Care Planning, 2011)
Respecting Choices LADS II Study

• 400 adults who died in 2007/8
• 90% had Advance Directives
  – Of these, 99.4% were in the medical record
  – 67% had a POLST
  – Preferences regarding CPR and hospitalization were consistent with treatment decisions in 99.5% of cases

Respecting Choices® ACP System

• Planning is an on-going process
• Plans become more specific as patients’ illness progress
• Plans are converted into medical orders that can be followed as a person changes settings of care
• Recognizes that people’s preferences change over time
Benefits of Advance Care Planning

- Honors people’s healthcare preferences
- People are not over-treated or under-treated
- People receive care in their preferred location
- Reduces moral distress for professional caregivers
- Reduces family/healthcare agent’s distress of “not knowing” if they made the right decision

(Creating Person-Centered Care When It Matters Most: Lessons Learned at Gunderson Health System, p. 17, Having Your Own Say, Hammes BJ 2012)

Honoring Your Wishes

HYW Steering Committee & Task Forces

- Advance Directive Task Force
- Community Engagement Task Force
- Document Storage & Retrieval Task Force

Honoring Your Wishes
Advance Directive Task Force

- To continue to review the HYW Health Care Directive document, receiving feedback from facilitators, professionals, and the community
- To make changes based upon feedback, changes in advance directive laws, research, and national trends

Community Engagement Task Force

- Develop annual community education & media relations campaigns
- Review community education materials & guidelines for use
- Assist in strengthening diverse community collaborations
Document Storage & Retrieval Task Force

• Monitor solutions such as registries, health information exchanges, personal health records, and national trends

• Analyze, review, and implement Respecting Choices recommendations
  – Prompts in electronic medical records for healthcare professionals to initiate conversations with patients
  – Storage and retrieval of written plans and documents
  – Mechanism to make referrals to ACP facilitators

Documents Used to Honor People’s Wishes

• HYW Health Care Directive
  – DPOA-HC

• IPOST
  – Medical order
What is different about the HYW Health Care Directive?

- Person-centered
- Specific
- Tool for discussion
- Written at a 9th grade reading level

Successes, Barriers, and Themes in *Honoring Your Wishes* Pilot Studies
2011 *First Steps* Pilot Studies

- IC/Johnson County Senior Center
- Mercy Home Health
- Consultation of Religious Communities/First Christian Church
- UIHC staff
- Oaknoll independent and assisted living residents

Honoring Your Wishes

2012 *First Steps* Pilot Projects

- Melrose Meadows
- UIHC Dialysis Services
- UIHC Pilot Project
- Mercy IC staff
- New Song Episcopal Church

Honoring Your Wishes
Outcomes

• Greater than 50% of people invited to participate in an advance care planning facilitated discussion will agree to schedule an appointment with a certified facilitator

• Greater than 50% of people who participate in an advance care planning facilitated discussion will review (revising as needed) an existing advance directive or complete an advance care plan

• 90% of participants will agree to have a conversation with their Health Care Agent (Durable Power of Attorney for Health Care)

Outcomes

• 90% of participants who receive care from a licensed independent provider will agree to give their written plans to their designated provider

• 90% of participants who complete satisfaction surveys will rate the helpfulness of the ACP discussion at 4 or 5 on a scale from 1 (not at all) to 5 (very much)

• 100% ACP facilitators will maintain a log of discussions
Quotes from participants

I was very much captured by the vision for the community and found the specificity of the discussion with the facilitator to be helpful.

I was surprised at the new ideas.

That’s the most he’s ever talked about things ever.

It was helpful to have the information for how to talk with family and friends.

Quotes from facilitators

Huge relief to complete my own as well.

The addendum was a good place to start the conversation. Many felt relief after going through this process.

This model encouraged other family members to have discussions and complete advance directives.

Honoring Your Wishes
Successes

- Groups recognized that ACP is a continuous quality improvement process
- Pilot project leaders recognized the value in writing a summary & presenting material
- Relationships were strengthened
- Faith-based settings allowed for more in-depth planning
- Sustainability plans were developed at each pilot site

Challenges/Barriers

- Belief that family members know preferences without a discussion
- Belief that current documents are adequate without reviewing them
- Making time to have facilitated discussions
- Having adequate staff & volunteers to offer advance care planning discussions
- Developing scheduling processes
- Scheduling second appointment
Themes

• Engagement needs to be very intentional
• Group engagement works very well
• Follow-up is key
• Leadership is vital to success
• People were very satisfied with the process
• Community leaders can assist in the initial process of advance care planning. ACP facilitators need to be selected very carefully.

Honoring Your Wishes

ACP Leadership Opportunities for Hospice & Palliative Care Providers

Honoring Your Wishes
How can hospice & palliative care providers provide leadership in advance care planning?

Advance Care Planning Leadership Opportunities

• Utilize HYW Health Care Directive with individuals and families
• Become a Certified Respecting Choices® First Steps Facilitator
• Promote advance care planning with colleagues
• www.honoringyourwishes.org
Advance Care Planning
Leadership Opportunities

• Engage faith communities and civic groups in the importance of advance care planning
• For adults with decision-making capacity who are appropriate for IPOST, ask if their advance directive is current or if they would like to have it updated

Honoring Your Wishes

The future depends on what we do in the present
- Mahatma Gandhi

Honoring Your Wishes
References

Hammes BJ. Editor. 2012. *Having your own say*. CHT Press. Wash, DC.


Honoring Your Wishes