Effectively Using ACP Services as a Foundational Initiative for a Successful Palliative Care Program

May 2025

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Agenda

- **Discuss the alignment of Advance Care Planning (ACP) and Palliative Care.**
- **Discuss differences between ACP documents specific to Michigan.**
- **Discuss legal requirements for Advance Directives.**
- **Discuss approaches to promote person-centered ACP conversations.**

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Program Development

- Organizational Interest in a Palliative Care Program in 2005
- Program Development revisited 2014
  - Assigned to Critical Care
  - Advanced Illness Management (AIM) meetings
  - Respecting Choices Advance Care Planning Training
  - End of Life Nursing Educational Consortium (ELNEC) Training
  - Center to Advance Palliative Care (CAPC) Conference Attendance
    - **Operational and System Assessments completed**

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Operational Self Assessment

CAPC

Involves assessing Program Features, Developing an Action Plan, and Identifying Potential Barriers

- Program Administration
- Types of Services
- Availability
- Staffing
- Measurement
- Quality Improvement
- Marketing
- Education for staff
  - Relevance to Strategic Plan
- Bereavement Services
- Patient Identification
- Continuity of Care
- Staff Wellness

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System Assessment

CAPC

Involves assessing System Characteristics aligned with Palliative Care Philosophy

- Vision and Management Standards
- Practice Standards (Procedures, Policies, Care Protocols)
- Space and Visitation Standards
- Spiritual, Religious, and Cultural Standards
- Bereavement Support Standards
- Psychosocial and Emotional Standards
- Communication Standards
- Professional Experiential Education during Orientation and as Continuing Education
- Individual Performance/Competency Standards
- Community Network and Partnerships

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Operational & System Assessment Results

Results supported Advance Care Planning as:

- Strongest Palliative Care resource
  - Policies in place
  - ACP specialized trained staff
- Limited ACP resources across inpatient and outpatient settings
- Created a path to enhance additional Palliative Care resources

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ACP - Key Component of Palliative Care

Symptom Management

Dyspnea, Constipation, Fatigue, Nausea, Vomiting, Pain, psychosocial symptoms.

Advance Care Planning

A process of communication focused on future health care decisions; identifies a medical decision maker, code status discussion, creation of ACP documents. Often transitions to Goals of Care.

Clarification of Goals of Care

Aligning medical treatments *with the patient's goals and* preferences for care.

Facilitation of Family Meetings

Discussions about what is the current condition, what to expect and where to we go from here, complex family issues.

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Basic and Specialized Palliative Care

Basic Palliative Care

- Palliative care that is delivered by health care professionals who are ***not*** palliative care specialists.
- Symptom management, ACP, and goals of care.

Specialized Palliative Care

- Palliative care that is delivered by health care professionals who are palliative care specialists.
- Complex symptom management, discussing ACP specific to illness, deeper goals of care conversation

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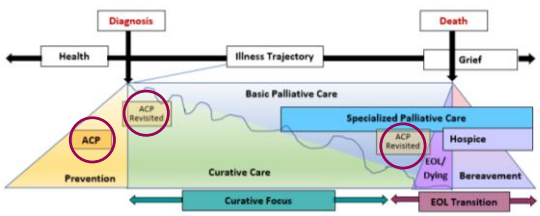
PC & ACP Across the Life Span



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Pre-Program Development

Strengthening ACP and Basic Palliative Care workflows & knowledge

Conference: Moments in Time: Palliative Care Introduction & End-of-Life Conference

- 130 multi-disciplinary attendees
- Agenda
  - **Introduction to Palliative Care Across the Continuum of Care**
  - History of Palliative Care
  - **Advance Care Planning**
  - EOL Communication
  - EOL Pain Control

Active Participation in Michigan ACP & Palliative Care Groups

CAPC conference attendance

Policy Revision and Education

- Pain Management
  - EMR documentation update - non-verbal pain assessment tool
- Medical-Decision Maker
  - EMR documentation update
- Advance Directive
- Resuscitation Policy
- Delirium Policy – New
- Capacity Determination Policy - initiated

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Palliative Care Proforma

CAPC

- Volume
  - CAPC calculated Palliative Care appropriate volume (5% of FY discharges)
  - Covenant Palliative Care initial projected volume 152 patients – 0.5% Penetration
- Benefits
  - Closed gaps in ACP resources
  - Patient & Family Satisfaction
  - Clinician Satisfaction
  - Increased Critical Care Bed Capacity
  - Reduced Readmissions
  - Financial
    - Reduced inpatient LOS – projected 103 days
    - Increased Hospice Days

Approved August 2016
for 1.25 FTEs
1 RN
0.25 Physician Lead

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Early Program Initiatives

Positions filled in February of 2017

- Site visits with existing Palliative Care Programs
- Recruitment for Palliative Care Certified Provider
- Education

- Billing
- Marketing
- Collaboration with existing teams
- EMR workflows developed

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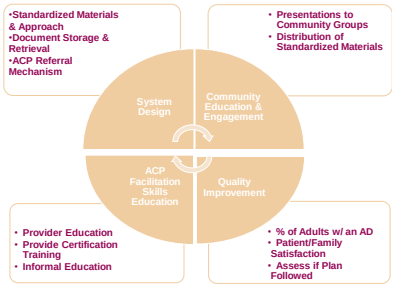
ACP Program Design Approach



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ACP Facilitator Training

- Respecting Choices – Leading ACP Model.

- Enhance communication skills to assist with ACP conversations.
- Create consistent workflows.
- Develop ACP resources within the system.

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Stages of Person-Centered Decision Making

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Palliative Care Services Initiated

- October 2017 - ACP visits initiated in both inpatient and outpatient settings
- May 2018 – Palliative Care visits started with the inpatient Trauma population
- September 2018 – Certified Palliative Care Provider and Occasional RN/ACP Facilitator joined the team

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Palliative Care Training

Palliative Care Team:

- CAPC Conference
- Four Seasons Palliative Care Immersion Course

Education to key stakeholders

- Interdisciplinary Teams
  - Cancer Care Center, Trauma Team, CMU residents and medical students, Heart Failure Clinic, COPD committee, ECC Geriatrics group, Hospice and Home Care, Case Management, Care Managers, PHO, Critical Care Committee, Hospital Medicine

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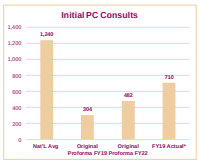
Palliative Care & ACPVolumes

- FY18: Average 10-20 new consults/month for Palliative Care
- FY19: Average 50-60 new consults/month for Palliative Care by end of Q4; Total of 710 patients seen
- FY19: Average 20 ACP visits/month



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PC & ACP Metrics

- **FY19 Advance Directives:** 10% increase from baseline in # of adults 65+ w/ valid AD ❯10 PCP offices
- **FY19 Code Status:** Goals of care and ACP conversations often led to a change in POC
  - Over 50% changed code status from Full Code to DNR; About 25% made a transition to AND-CMO (comfort care)
- **FY19 Cost of LOS:**
  - Costs for pts. w/ PC seen and discharged alive were $35,449 compared to $37,447 without PCCS.
  - Costs for pts. w/ PC who died during hospitalization were $54,940 compared to $79,660 for patients who did not receive PC.
- **FY19 Discharge Disposition:** 24% DC w/ Hospice

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Additional FTE approved

- **High volumes and successful metrics led to the approval of an additional full-time provider for the inpatient setting in November 2020**
  - **The onboarding timeframe was short as the provider had completed a Palliative Care rotation during NP school.**
- **Readmission rate metrics captured:**
  - **FY21 Readmission Rate:**
    - Comparison Group: 23.72% (Patients w/ a Risk of Unplanned Readmission Score > 26%)
    - Pts. w/ PC consult: 14.98%

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Mission, Vision, and Values

Mission

Palliative Care: To improve quality of life for patients with serious illness by addressing physical, psycho-social, emotional and spiritual wellbeing.

Advance Care Planning: Develop a community wide comprehensive person-centered ACP program.

Vision

Palliative Care: To be the leader in palliative care services in the tri-city area by providing highest quality palliative care throughout the transitions of care.

Advance Care Planning: To be the leading ACP program within the tri-city area.

Values

- **W**orking Together - Provide an extra layer of support to patients, families, the community, referring providers and other members of the health care team
- **E**xcellence - Implement care based on national quality standards and evidenced-based practice
- **C**ustomer Service - Maintain a Person/Family Centered Focus of Care
- **A**ccountability - Monitor both clinical and operational quality metrics
- **R**espect - Create a plan of care based on individual goals and preferences
- **E**nthusiasm - Promote Team Wellness and Professional Growth

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Outpatient Development

- 2018-2019 Brainstorming and conversations began with inpatient Palliative care on potential models and support needs
- Outpatient Palliative Care program proforma was presented and approved in March 2020 just before COVID shutdown. NP was hired for the outpatient area and began training with the inpatient team.
- VNA Palliative Care proforma was slated to start FY21. Due to the COVID-19 pandemic, it was delayed. FY22 was considered the first year of the program with the initial proforma of:
  - 0.5 NP
  - 0.6 SW
  - 0.09 RN liaison
  - 0.3 Billing
  - Chaplain- supported by Hospice Chaplain
- In April 2022, a new proposal was approved to add 1 provider to VNA outpatient Palliative Care. This was due to the volume and success of Hospice transitions from outpatient Palliative Care.

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Merging of Palliative Care Services

An increased demand was noted for both inpatient/outpatient teams, leading to the following challenges:

- Covenant Inpatient and VNA outpatient Palliative Care programs function separately with different leadership
- Referrals and demand are overwhelming both programs, and resources are limited
- Initiatives for each area are starting to cross (ACP, community outreach, need for provider cohesiveness for patient care, outpatient clinic goals)
- Provider burnout
- Lack of direction and focused organizational strategy

Action was needed to address the above challenges

Reason for Action "The Why": There was a deficit in the continuum of care for Palliative services at Covenant Healthcare.

Goal: Realign the strategy and model for Palliative Care Services at Covenant Healthcare by combining the inpatient and outpatient programs to provide a stronger and more targeted approach to Palliative medicine within the organization.

Merge approved and took place July 1, 2023

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Current Palliative Care Program Services

Inpatient:

- Average daily census - 25 patients
- M-F coverage 7a-7p
- After hours & weekends on-call coverage
- 4.25 Providers
- Support of General Inpatient Hospice (GIP)

Outpatient: Home, Clinic, SNF, ALF

- Current census – 270+
- M-F coverage 8a-4:30p
- Evenings & weekends on-call coverage
- 2. 5 Providers

Two Clinic Locations:

Embedded within Cancer Care Center

- Two days a week by appointment
- After hours & weekend on-call coverage
- 0.5 Provider

Palliative Care Clinic near the main campus

- One day a week by appointment
- After hours & weekend on-call coverage
- 0.25 Provider

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Palliative Care Team

Leadership:
Director: Diane Glasgow, OT/L, MHA
Manager: Katie Parkhurst, BSN, RN
Coordinator: Tiffany Leiter, BSN, RN, LMT

Providers:
Dr. Melodie Knicely – part-time; Physician Lead; inpatient
Summer Bates, NP – Lead NP; inpatient and clinic
Chris Benson, NP - inpatient
Liz Fulton, NP – occasional – all settings
Neil Stokes, PA – outpatient and clinic
Jayne MacDonald, NP - outpatient
Rachael Wernette, NP – occasional, outpatient
Renee Robbins, NP - inpatient
Chelsea Jensen, NP – inpatient

Social Worker: Melissa Johnson, MSW
Volunteers: *Connie O'Toole*-Kettlehorn & Kathy Hudson

Nurses:
Advance Care Planning (ACP):
Tracy Bargeron, MSN, RN – ACP & Community Outreach Specialist
Della Brown, BSN, RN – ACP Facilitator

Liaisons, Quality & Intake/Triage Support:
Carly Rogue, BSN, RN – Palliative Care
Cindy Cole, RN & Amanda "Mandy" Wilson, RN – Hospice
Jaclyn Weisbarth, RN – Quality for PC & Hospice
Emily Weisbarth, RN – Intake/Triage Support

Pastoral Care: IP – on-call chaplains; OP-Chaplain Mike Leiter
Chaplain Elizabeth Palmer – Pastoral Care Palliative Care Fellowship

Community Relations: Kaitlin Veihl, MBA

Ad Hoc
Respiratory, Pharmacy, PMR, CRM, Outpatient Services, Dietician, Massage Therapy, and more

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Michigan Advance Care Planning Documents

- *Advance Directives*
- *Medical Orders*
- *Miscellaneous*

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Types of Advance Directives

- **Durable Power of Attorney for Health Care (DPOA-HC)**
  - Includes designation of a patient advocate AND *may include a person's* wishes
  - Alternative titles:
    - Patient Advocate Designation
    - Medical Power of Attorney
  - Common misconception that General POA gives medical decision-making rights
    - On rare occasions a General POA may contact DPOA-HC content
- **Living Will**
  - Contains statements of treatment decisions
  - DOES NOT usually designate a patient advocate

Legal requirements driven by state law

Living Wills are not *legally* recognized in Michigan.

May be used as good intent.

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Portable Medical Orders

- **Out of Hospital DNR (OOH-DNR) orders**
  - Only addresses DNR wishes
- **Michigan Physician Orders for Scope of Treatment (MI-POST)**
  - Includes treatment preferences
    - Full Resuscitation or DNR
    - Specified Medical Orders for: Comfort, Selective, or Full Treatment
    - Additional orders (TF, dialysis, blood, products, etc.)
  - Consists of two documents
    - MDHHA-5836, Michigan Physician Orders for Scope of Treatment (MI-POST)
    - MDHHS-5837, Michigan Physician Orders for Scope of Treatment (MI-POST) Patient and Family Information Sheet

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Comparison of OOH-DNR Order & MI-POST

	Out-of-Hospital DNR	MI-POST
Who can have the document?	Any Adult, regardless of health status. Minor with advanced illness.	Adult with advanced illness or frailty (12 months or less life expectancy).
Required Signatures	• Adult with capacity (or patient advocate or guardian) • Parent on behalf of a minor • Two witnesses (only one can be a family member; no family member if guardian is signing) • Physician (cannot be NP or PA)	• Adult with capacity (or patient advocate or guardian) • Physician, NP or PA • Person assisting with form completion (if applicable)
Does it expire?	No.	Yes, after 12 months (may be reaffirmed). Must be reaffirmed within 30 days from change in patient's: Attending Physician, Care Setting, or Unexpected Change in Medical Condition.
Must it be on special paper/color?	No. Copies: electronic, paper, and photo are acceptable – individual county Medical Control Authority (MCA) may have specific requirements.	Yes, documents must have pink border. Copies: electronic, paper, and photo are acceptable.

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Miscellaneous

- **Capacity Determination**
  - Documentation of Capacity or Incapacity.
  - Only a Physician or Licensed Psychologist may determine the level of capacity.
  - Determination may be dependent on the complexity of the decision.

See handout

- **Facility-Specific Treatment Wishes**
  - Treatment preferences to be honored within a specific facility
- **Authorization to Disclose Protected Health Information (HIPAA Release form)**
  - Designation of individuals who may receive health information (**no decision-making rights**).
  - Common alternative titles:
    - Nomination of Agent as Healthcare Personal Representative
    - Authorization for Patient Representative

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Validation of Advance Directives

Michigan Legal Requirements

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Signatures

Advance Directive: Legal Requirements

Requires the following signatures:

- **An adult who has decision-making capacity - "Patient"**
- **Two witnesses**
  - Limitations - Cannot be:
    - Less than 18 years of age
    - **Primary or Successor Patient Advocate**
    - *Patient's spouse, parent, sibling, child, grandchild or* **presumptive heir**
    - A known beneficiary at the time of witnessing
    - An employee of a health or life insurance provider for the patient
    - **An employee of a healthcare facility that is treating the patient**
    - A healthcare provider currently involved in the treatment of the patient
- **Patient Advocate(s) (before authority to make medical decisions is activated)**
  - May sign at any time
  - ***Recommended to have all advocates sign as soon as feasible***
  - Does not require witnessing

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Patient Advocate Designation

Advance Directive: Legal Requirements

- **Divorce or legal separation voids the previous designation of a spouse as a patient advocate.**
- Changes in the order of patient advocate designation or adding a patient advocate require a new document to be completed.
- Patient Advocate may revoke previous acceptance of patient advocate role verbally or in writing.
- Patient Advocate Designation may be revoked verbally or in writing.
  - Patient may revoke designation even if found to be incapacitated.

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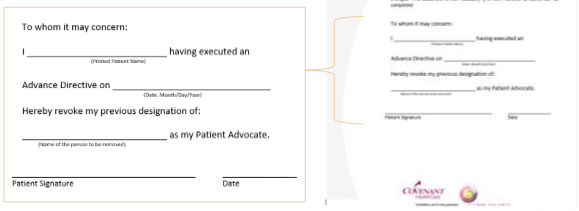
Sample of Written Revocation Letter



To whom it may concern:

I _____ having executed an
(Printed Patient Name)

Advance Directive on _____
(Date: Month/Day/Year)

Hereby revoke my previous designation of:

_____ as my Patient Advocate.
(Name of the person to be removed)

_____ _____
Patient Signature Date

Revocation of Patient Advocate Designation

To whom it may concern:

I _____ having executed an

Advance Directive on _____

Hereby revoke my previous designation of:

_____ as my Patient Advocate.

_____ _____
Patient Signature Date

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Sample of Verbally Requested Revocation Letter

Revocation of Patient Advocate Designation

Regarding the Advance Directive completed on _____.
(Date: Month/Day/Year)

_____ shared a verbal request to revoke
(Printed Patient Name)

his/her previous designation of:

_____ as his/her Patient Advocate.
(Name of the person to be removed)

_____ _____
Signature of person receiving request Date

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Treatment Wishes

Advance Directive: Legal Requirements

- **Treatment wishes are optional.**
- **Must state the authority to withhold life-sustaining treatment *(if desired)*.**
- **Authority to make Mental Health decisions must be specifically stated.**
- **Organ donation registry overrides an Advance Directive stated wishes on organ donation.**
- **May include funeral arrangements – (recommend Funeral Representative Form instead).**
- Treatment preferences included in an Advance Directive ***serves as a guide, primary to patient advocates.*** If DNR wishes are desired, additional documentation is needed.

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Reaffirming of Advance Directive

Recommend reaffirming previously created Advance Directive periodically.

Consider the five "Ds"

- **Decade**
- **Divorce**
- **Death**
- New **Diagnosis**
- **Decline** in health status

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Approaches to promote person-centered ACP conversations

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ACP Collaboration

ACP is not one person's responsibility. Basic ACP services should be a shared process that offers consistency with the information shared.

- Reach out to key stakeholders:
  - PCP offices
  - Specialist: Oncology, Orthopedics, Cardiology
  - Case Managers
  - Community groups
  - Admitting
  - Pre-admission Testing (PAT)

A consistent system approach focused on what matters most to the individual is key.

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Introducing ACP

- Begin by sharing the importance of an Advance Directive (AD) and normalize the recommendation.
- Inquire on existing ACP documents during PCP wellness visit & initial specialty visits.
- *"Have you created an AD **or Power of Attorney for Health Care or any document naming who you want to be your medical decision maker if you ever need one**?"*
- If no existing document
  - Share importances of creating an Advance Directive
    - Designating a patient advocate
    - Michigan does not have a Family Consent Law
    - *Promotes alignment of care with individual's goals and values*
  - Provide basic information to review

Many people believe an Advance Directive is only needed if you wish to limit care received. So, it is important to provide education that the AD may include care they do want.

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Introducing Scripting

New Patient

"It is important to plan for the future, and an advance directive can help share your preferences with your health care team."

General

"As we never know when a crisis can occur, we recommend every adult create an Advance Directive to assure the person you want is contacted."

Follow up post discharge visit.

"I am glad you are doing better. Would it be okay if I asked if this experience would have been different, who would you trust to help make the right medical decisions for you?"

"It always seems too early, until it is too late."

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Address common responses

"I want my oldest daughter to make decisions."

"Having an Advance Directive in place that will designate your daughter can help ensure this is the person the health care team reaches out to if ever needed?"

"Michigan does not have a Family Consent Law. Although most hospitals have a policy naming a decision-maker hierarchy, this is not law."

"My family knows my wishes."

"That's great that you have shared your wishes. There are some circumstances when a legal document is required to allow your family to make certain decisions."

"My spouse will make decisions."

In addition to the above, share a situation where a spouse may not be able to act as a patient advocate: "What if you are both in an accident?"

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Introduction with New Diagnosis

"As we never know when a crisis can occur, we recommend every adult create an Advance Directive to assure the person you want is contacted. ***This is even more important for someone who has a health condition"***

When prioritizing patients, consider age, as well as individuals noted to be at higher risk of losing capacity within the next year, such as:

- Patients with early Dementia
- Patients with COPD, organ failure (ESRD, HF), Advanced Cancer, ALS
- Patients with frequent readmissions

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Preparing for ACP Conversation

Detailed chart review:

- Past and present medical history
- Recent hospitalizations
- Pre-existing AD

Have a pre-meeting with others on the healthcare team.

Ask for the patient's permission.

Explain what will be discussed and ask the patient if there are topics they would like discussed.

Location:

- Quiet private place with enough seating for everyone.

Plan who will be present:

- *Patient's family/friends.*
- Offer phone conferences for individuals who cannot be present.
- Members of the patient care team.

Set aside an appropriate amount of time.

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ACP Conversation

- **Understanding of ACP and Advance Directives**
- **Assistance with identifying a decision-maker**
- **Understanding of health status**
- **Past experiences with serious illness**
- **Learning what matters most to the individual**
- **Goals in the event of a serious brain injury**
- **Understanding of CPR**
- **Preparing patient advocates to understand their role**
- **Assistance with creating appropriate ACP documents**

Exploration

Begins transition to Goals of Care

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Communication Skills

- Exploring meaning of words/phrases
- Paraphrase/clarify
- *Ask, "Anything else?"*
- Listen for and summarize themes
- Affirm/reaffirm purpose of conversation
- Verbalize empathy
- Use the Ask-Teach-Ask technique
- Remain value-neutral
- Pay attention to nonverbal communication

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Introduction and Understanding of ACP and Advance Directives

- Introductions
- Ask what they understand the purpose of an Advance Directive
  - Important to address any misunderstandings
- If they have a pre-existing Advance Directive (AD), ask what conversations they had with their advocates.
- Ask if they have any concerns or questions about completing the AD

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Assistance with Identifying a Patient Advocate

Key qualities

- Accepting of the role
- Willing to talk about health status, goals, values and preferences
- Willing to honor decisions, even if he/she does not agree with them
- Able to make good decisions in a crisis
- Easily contacted

Additional tips:

- Recommend at least one successor
- Offer handouts describing the role of a patient advocate.
- Ask how they will explain the role to their patient advocate(s).
- If a patient advocate is present, include them in the conversation.
- Share that your conversation will assist with preparing for this role.

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Understanding of Illness

Begins with asking permission and assessing understanding.

Ask the patient to share their understanding of their illness.

"Tell me what you understand about your medical condition(s)."

"Tell me how things have been for you over the last year to six months."

"What problems do you think you may have in the future?"

"Would it be ok if we talked about what lies ahead with your illness?"

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Listen for Gaps

Understanding of Illness

Listen for gaps in understanding and offer time to share information. *"Anything else?"*

IF they have a good understanding

"It sounds like you have a good understanding of your illness. Thank you for sharing."

Ask any family present if there is more to share.

"Given where you are in your illness, this seems like a good time to talk about where we go from here."

IF they do not have a good understanding.

Non-providers:

- Write down questions to take to their provider.
- Offer general information.

Providers:

"It seems that we are in a different place now than we were 6 months ago."

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Past Experiences with Serious Illness

Explore experiences with past illness with someone close to them.

"Tell me briefly about any experiences you have had with family or friends who became seriously ill or injured."

Often, past experiences with someone close to them may influence their health care preferences for themselves.

Listen for any gaps.

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Expect Emotion

Understanding of Illness

Talking about their illness may be very hard for them, especially if there is new information regarding a decline…*you will likely have emotions*. Tend to the emotion before moving on or the rest of the conversation may not be successful.

- **Pause to allow time for emotion.**
- **Respond to the emotion by acknowledging it and providing empathetic responses.**

"I can see you are very concerned about this"

(most of the time they will start talking more after you say something like this)

An emotional response may come out as a question.

"Are you just giving up on me?"

"Are you sure there is nothing else that can be done?"

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Learn What Matters Most

Explore views on quality of life *before making a plan.*

Explore what they do for enjoyment and their values and beliefs.

"What gives life meaning?"

"Do you have any beliefs of values that may influence medical decisions?"

You may simply ask what life is like outside of the hospital for them.

This can be a difficult conversation to start if their illness is already limiting their functional status.

"As you think towards the future, what concerns you?"

"Knowing time may be limited, what things are most important to you?"

This is where you can gain valuable information to assist with goals of care conversation.

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Explore Goals with a Severe Decline in QOL

Begins transition to Goals of Care conversation.

Transition the conversation by linking the information they have shared to this phase of the conversation.

Opens opportunities for the individual to talk about acceptable and unacceptable outcomes.

Imagine this situation: *"A sudden event, such as a MVA or stroke, left you unable to care for yourself. Your care team believes that it is **very unlikely** that you will recover to know who you are or who you are with?"*

Confirm understanding of the situation.

"In this situation, would you want life-sustaining treatment continued or initiated? Either way, you will still get the care you need to keep you comfortable."

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Explore understanding of CPR

Normalize the conversation.

"I would like to talk about CPR as a decision about CPR is one of the most commonly asked questions someone has to make. Is that okay?"

Most people believe CPR is successful over 50% of the time. It is important to explore their understanding and educate them so they can make an informed consent.

"What do you understand about CPR?"

"What has your doctor told you about CPR?"

"What do you know about the success rate of CPR?"

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CPR Education

Ask permission to share general education on CPR.

Education should include:

- Reinforcing heart & breathing have stopped – Death has occurred.
- Components of CPR
- Success rates
- Possible outcomes
- How wishes are shared via code status

- Components of CPR
  - Chest compressions, defibrillation, cardiac arrest medications, assistance w/ breathing
- Success rates
  - In-hospital: 20-25%
  - Out of hospital: 5-10%
  - Advanced Age: 5%
  - Advanced Illness: 1-2%
- Possible outcomes
  - Broken ribs, organ damage
- How wishes are shared via code status
  - Full, DNR, Comfort Measures
  - Clarify wishes for DNI

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Summarize the Conversation

Summarize the conversation.

- **Assures you understood correctly.**
- **The patient feels like they have been heard.**
- **Facilitates trust.**
- **Clarify fears**

"As I listen to what you have said it seems that _____ is most important to you, did I get this right?"

Transition to AD completion – ask if they are ready to complete the document.

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ACP Initiatives

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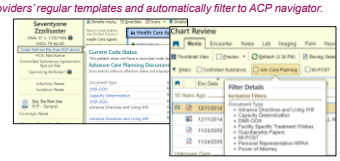
Create Easy ACP Workflows in EMR

- Smart phrases and text improve efficiency and trigger key components
  - ACP note for providers – include billing requirements.
  - Capacity note – *can be used in providers' regular templates and automatically filter to ACP navigator.*
  - ACP notes for all staff.
- ACP filters to easily locate ACP documents
- Standardized letters
- ACP referral order
- Create links in the EMR to OOH-DNR orders



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Collaborate w/ PCP and Specialty Areas

- Oncology, Cardiology, COPD, Medical and Nursing Schools, SNFs
- Educate staff on:
  - EMR workflows
  - Validation of Advance Directives
  - ACP Referral resource
- Assist w/ training a staff champion
- Group presentation in office

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Community Groups

Presentation and Vendor Event

- Presentation
  - Small Groups – provide Advance Directive and review page by page
  - Larger Groups – provide brochures and forms to request ACP materials be mailed
- Vendor Event
  - Forms to request ACP materials

- Churches
- Rotary Clubs
- Exchange Clubs
- Lions Club
- YMCA
- Chamber of Commerce
- Community on Aging
- Optimist Club
- MASC & PASC

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Other Initiatives

- Brochures & Flyers
  - PCP offices, hospital waiting areas, elevators
- ACP Website
- After Visit Summary (AVS)/Discharge Orders
- Open Forums
- TV & Radio presentation
- Senior resources

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Questions?

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