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Standardization of a Formal Advance Care Planning Model

A System's Change Project
Submitted to the Faculty
Of The Department of Nursing
Saint Catherine University

By
Jessica Ann Hinkley, RN, MSN, APRN, FNP-BC

In Partial Fulfillment of the Requirements
For the Doctor of Nursing Practice Degree

December 2011

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This is to certify that I have examined this

Doctor of Nursing Practice Systems Change Project

prepared by

Jessica Ann Hinkley, RN, MSN, APRN, FNP-BC

And have found that it is complete and satisfactory in all respects, and that any and all revisions required by the final examining committee have been made.

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Name of Faculty Project Advisor

November 30, 2011

Date

Saint Catherine University

DEPARTMENT OF NURSING

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EXECUTIVE SUMMARY

Planning for health care needs is a responsibility that requires informed decision making, time, and individualized attention. Advance care planning (ACP) is an organized process of communication that is intended to assist, engage, and support health care consumers, their families, and the involved health care professionals in understanding, reflecting upon, and discussing the individual's goals, values, and preferences for their present and future health care needs (Respecting Choices, 2007). ACP an appropriate intervention for all adult health care consumers particularly those with chronic disease or advanced illness.

Fairview Red Wing Health Services (FRWHS) is among many health care organizations worldwide that have failed to incorporate ACP as a routine standard of care. This descriptive systems change project (SCP) was developed to address the inadequate utilization of ACP for individuals and families referred to the FRWHS Palliative Care program. The purpose of this SCP was to identify if the implementation of a formal ACP model would foster the initiation, utilization, and standardization of ACP processes by FRWHS health care professionals for patients referred to Palliative Care. In collaboration with the Honoring Choices Minnesota ACP collaborative, FRWHS initiated and implemented a formal ACP model. This SCP included electronic medical record (EMR) audits and educational interventions. EMR audits were conducted to evaluate ACP documentation practices of health care professionals who referred patients with chronic disease or advanced illness to the FRWHS Palliative Care program prior to the intervention (referred to as no intervention EMR audits). Educational interventions were implemented to enhance ACP awareness and knowledge for FRWHS staff. Following the implementation of interventions, EMR audits were conducted to evaluate if the interventions elicited change (referred to as with intervention EMR audits). It was intended that initiation and

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implementation of a formal ACP model would facilitate the utilization and standardization of ACP processes, ensure compliance with ethical and legal requirements, and ultimately provide higher quality patient care throughout FRWHS. Although this SCP was not statistically significant in its entirety, the implementation of the formal ACP model and educational interventions did elicit change for the FRWHS Palliative Care program. Implications for present and future practice and research have been identified as a result of this SCP.

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CHAPTER I

Facing injury and illness can be terrifying. Support, advocacy, and information are necessary to facilitate informed decision making as well as to enhance effective coping skills. Individuals and families facing illness or injury need to be, and have the right to be, fully informed and educated on their rights and choices with respect to their health care. Whether the illness is acute or chronic, health care professionals have the opportunity to provide guidance for decisions made regarding implementation or deferral of medical interventions. The quality of one's life may be seriously jeopardized if, and/or when, this guidance is managed ineffectively, or is not offered (Larson & Tobin, 2000). Thus, it is essential that providing guidance for individuals and families experiencing chronic disease or advanced illnesses becomes a routine aspect of the advance care planning process and every day health care. The purpose of this systems change project (SCP) is to identify whether or not the initiation of a formal advance care planning model, including education, access to certified advance care planning facilitators, and a systematic referral process will enhance the utilization and standardization of the advance care planning process for individuals with a diagnosis of chronic disease or advanced illness whom are referred to the Fairview Red Wing Health Services (FRWHS) Palliative Care program. The educational interventions included in this SCP will target health care provider and health care professionals by enhancing awareness and increasing knowledge of recommended ACP processes.

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Background

Life encompasses much more than one can begin to prepare for, and far beyond what one's imagination can fathom. In the midst of life's blessings there are challenges and hardships. More often than not, those challenges and hardships occur when one least expects, and when one is the least prepared. Life, health, and illness all entail a continuum of choices, and thus, a spectrum of decisions. Attention, time, and consideration are needed to make choices and decisions. Decisions are most often made based on goals, morals, values, and an individual's understanding and knowledge of their choices. An individual's understanding and perception of the consequences and/or implications of all options will affect how decisions are made.

Advance care planning (ACP) is an organized process of communication that is intended to assist, engage, and support health care consumers, their families, and the involved health care professionals in understanding, reflecting upon, and discussing the individual's goals, values, and preferences for their present and future health care. The process of ACP is an essential intervention when working with adult health care consumers, particularly those with chronic disease or advanced illness. Unfortunately, ACP is often avoided, neglected, and/or managed ineffectively (Respecting Choices, 2007). ACP incorporates the process of therapeutic communication with informed consent, autonomy, patient advocacy, human dignity, and compassionate care. These qualities are both ethically and legally necessary when assisting and supporting health care consumers, families, and their chosen health care team in making informed decisions (Goodwin, Kiehl, & Peterson, 2002). When the ACP process is managed and conducted well, it has the power to result in ongoing conversations that are accompanied by a written plan. A written advance care plan is often in the form of an advance health care directive. Ideally, if a written plan or advance health care directive is developed, it will

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accurately represent the individual's health care preferences which will prepare others if and/or when necessary to render health care decisions that are most consistent with their loved one's health care preferences (Respecting Choices, 2007).

FRWHS is an integrated health system located in rural Southeast Minnesota with one of the branch clinics extending into rural Wisconsin. FRWHS serves a population of approximately 50,000 health care consumers. FRWHS is unique in that it is the only health system within a 20 mile radius. FRWHS includes Fairview Red Wing Medical Center, Fairview Red Wing Community Services, Fairview Seminary Nursing Home, and Deer Crest Assisted Living. As an organization, FRWHS has ambulatory, surgical, inpatient, urgent care, and emergency services. The ambulatory services within FRWHS include: Family Practice (including Obstetrics), Gynecology, Pediatrics, and Specialty Medical Services (including Oncology), Gastroenterology, Rheumatology, Nephrology, Cardiology, Pulmonology, Neurology, Palliative Care, and Infusion Therapy. In addition, FRWHS offers ambulatory Surgical Services in, Orthopedics, Podiatry, Ophthalmology, Ears, Nose, and Throat (ENT), and Urology. The inpatient units within Fairview Red Wing Medical Center have the capacity for 40 medical-surgical-pediatric patients, four intensive care patients, and six labor and delivery patients. Fairview Red Wing Community Services include Home Care, Hospice, and Behavioral Health Services. Fairview Seminary Home is a long term care facility that is owned by FRWHS. Deer Crest Assisted Living provides independent living, assisted living, and a memory care unit which are all located on the Fairview Red Wing Medical Center campus grounds.

In February of 2008, FRWHS began offering Palliative Care services in the ambulatory care setting. Palliative Care is a specialty of medicine that focuses on improving quality of life by providing comprehensive and holistic care to individuals and families who are confronted

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with chronic disease or advanced illness. The FRWHS Palliative Care program utilizes a multidisciplinary team approach to help individuals and families address the many physical, emotional, social, and spiritual needs that accompany chronic illness or advanced illness. Individuals and families confronted with chronic disease or advanced illness may be referred to the FRWHS Palliative Care program by a Primary Care Provider (PCP), health care professional, and/or family member. The FRWHS Palliative Care program is committed to helping and supporting individuals and families plan for their present and future health care through the process of ACP.

Providing quality patient care is a standard at FRWHS. However, the utilization and documentation of ACP at FRWHS is lacking. The literature reports that factors associated with the failure of health care professionals to incorporate ACP into practice include: feeling uncomfortable, feeling unprepared and threatened with the idea of discussing the topics that are the central focus of the ACP process. In addition, many health care professionals report lack of time and lack of reimbursement as barriers to initiating and utilizing the process of ACP. Health care consumers have reported they feel uncomfortable discussing ACP topics, and view such discussions and planning as irrelevant. In addition, many health care consumers admit they defer ACP as a result of feeling unaware and uninformed of their health care options even though they wish to pursue such involvement and planning (Respecting Choices, 2007).

FRWHS is among many health care organizations worldwide that have failed to incorporate ACP as a standard of care (Respecting Choices, 2007). Over the last several decades, the media has orchestrated the movement of ACP into health care headlines. With ratings in mind, the media has taken every opportunity, good as well as malevolent, to inadvertently portray the anticipated and potentially unforeseen tragic implications of inadequate

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or lack of ACP (Maxfield, Pohl, & Colling, 2002). As a result, the current health care system, as a whole, necessitates change that includes comprehensive ACP as both a standardized requirement of practice and a routine element of health care for all adults. As a health care system, FRWHS has ethical and legal obligations to standardize and incorporate the process of ACP into the delivery of routine health care (Goodwin et al., 2002).

Problem Statement

FRWHS believes that improving quality care, enhancing education, and providing comfort through the process of ACP, will help meet the goal of honoring the wishes of health care consumers and families in times of hardship. However, the current practice of ACP through FRWHS is inadequate in that the process lacks standardization, is not a routine aspect of every day health care, does not meet the needs of the health care consumer or professional, and does not conform to ethical recommendations.

Objective

Upon completion of this SCP, it is intended that:

> Implementation of a formal ACP model will foster the initiation, utilization, and standardization of ACP processes by all FRWHS health care professionals for patients with chronic disease or advanced illness that are being referred to the FRWHS Palliative Care program.

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Research Question

Will the implementation of a formal ACP model increase the utilization and standardization of ACP by all FRWHS health care professionals for patients with chronic disease or advanced illness that are being referred to the FRWHS Palliative Care program?

Research Hypothesis

It is hypothesized that the implementation of a formal ACP model will foster the initiation, utilization, and standardization of ACP by FRWHS health care professionals for patients with chronic disease or advanced illness that are being referred to the FRWHS Palliative Care program.

Summary

This SCP has been designed to implement, standardize, and evaluate ACP processes for the FRWHS Palliative Care program. Initiation, implementation, and standardization of a formal ACP model throughout FRWHS will help to ensure compliance with ethical and legal requirements, and will provide patients and their families with the support, informed consent, autonomy, patient advocacy, human dignity, and compassionate care that they are entitled. In the following chapters, a description of the theoretical framework, review of the literature, and development and implementation of the SCP will be reported. A thorough discussion of the results will conclude this paper.

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CHAPTER II

The following chapter will provide an overview of the theoretical frameworks that are congruent with and support the process of ACP and this SCP. In addition, a comprehensive literature review of ACP as it pertains to FRWHS and this SCP will be presented.

Theoretical Framework

Nursing is a profession that has been and continues to be shaped by numerous theories and ethical principles. Of utmost importance, nurses hold four fundamental responsibilities, including promotion of health, prevention of illness, restoration of health, and the alleviation of suffering. In addition to the fundamental responsibilities, nurses are responsible for respecting all human rights, including the right to life, the right to choice, and the right to be treated with respect (International Council of Nurses [ICN], 2006). The process and principles of ACP address and emphasize several basic patient rights. These patient rights include: informed decision making, autonomy, patient advocacy, human dignity, and compassionate care. Each of these patient rights are embedded within the ACP process and emphasize and support the rationale for the implementation of a formal ACP model at FRWHS. Following are the basic patient rights definitions as used for this SCP.

Definitions

Informed decision making, is used to describe a process designed to help health care consumers understand the nature of their health condition(s) and understand health care services including benefits, risks, limitations, alternatives, and uncertainties. Informed decision making is intended to help health care consumers consider their own preferences and values and allow participation in the decision making process at the level in which they desire. Ideally, informed

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decision making helps health care consumers make decisions that are most consistent with their own preferences and values (http://www.rwjf.org/qualityequality/glossary.jsp).

Autonomy, for this SCP, is defined as the inherent right and ability of an individual to make self determining choices for themselves. One's ability to be autonomous can be determined on the basis of the individual having the capacity to reason and make decisions. Respect for autonomy necessitates that that health care professionals view the individual as having the capacity to reason and make decisions for themselves, unless deemed otherwise. Respecting autonomy is viewed to be an ethically desirable and psychologically healthy intervention (Lowden, 2002).

Patient advocacy, which can be viewed as a strategic process, is defined as a series of specific and deliberate actions that preserve, represent, and safeguard patients' rights, best interests, and values (Bu & Jeweski, 2006). Patient advocacy is central to the role of the health care professional.

Human dignity is a basic human right that is often viewed as multidimensional. Human dignity is owned by all persons simply by virtue of being a human being. The right applies equally to all humans, regardless of capacity or lack thereof. Human dignity concerns how people feel, think, and behave in relation to the worth or value to themselves and others. All humans have equal worth and must be treated as if they are able to feel, think, and behave in relation to their own worth or value. To treat someone with dignity implies treating one as being of worth, value, and with respect. When treated in a dignified manner, humans will feel in control, valued, confident, comfortable, and feel capable of making decisions. When dignity is absent, people may feel devalued and feel they lack control, confidence and comfort in making

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decisions. Ensuring health care consumers are treated with human dignity is an inherent component of the ACP process (Jackson & Irwin, 2011).

Compassionate care is multidimensional and often viewed in a subjective context, rather than having an objective definition. Compassionate care, in the eye of the health care consumer is care that is delivered compassionately with sensitivity, empathy, respect, and without judgment (Harrison, 2009).

Theoretical Framework

This SCP was designed, guided, and conducted using the theories and ethical principles of Jean Watson, Imogene King, Leah Curtin, Sally Gadow, Mary Kohnke, and, by adhering to the principles, guidelines, and responsibilities of the profession of nursing as stated in the *International Code of Ethics for Nurses* (International Council of Nurses [ICN], 2006). These theories will be presented in the following paragraphs.

Caring

Jean Watson, a world renowned nurse theorist, acknowledges caring as the essence of the nursing profession (Watson, 1988b). Through caring, Watson suggests that nurses are in a unique position to assist and support individuals by preserving and ensuring human dignity. Through caring and helping, one can guide others in finding meaning in illness and suffering, as well as to promote or restore inner harmony (Cara, 2003). In Watson's theory of Caring, the individual is the focus of practice. The individual is viewed within the context of family, the community, and culture. Watson emphasizes that the nurse must focus on the learning process as much as the teaching process to foster holistic care. Holistic care is provided within a caring

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environment. Watson describes a caring environment as one that allows and supports the individual in determining the best action for him or herself at a given point in time. Prior to assisting in the development of a plan, the nurse must consider and fully understand the individual's perception and knowledge of the confronting situation (Current Nursing, 2009, March 16). Of central importance is the transpersonal caring relationship. The transpersonal caring relationship demonstrates care and concern by the nurse towards the individual and their experience beyond the functional duty of objective assessment and practical skills. Emphasis is also placed on the role of the nurse supporting and assisting the individual and their families to increase self-knowledge, self-control, and strengthen self healing. A result of this relationship is the protection, enhancement, and preservation of an individual's dignity, humanity, wholeness, and inner harmony are achieved (Cara, 2003).

Watson's theory of caring is congruent with and embedded throughout the purposeful intentions and rationale of ACP. These concepts emphasize the importance of viewing the person as a holistic being who is influenced and supported by family, and one who has previous knowledge and personal understanding of their state of health. Watson emphasizes it is essential to provide the individual and family with the information that they will need in order to make an informed decision, and assist with them in the development of a plan of care that is most consistent with their goals and preferences.

Goal Attainment

Similar to Jean Watson, Imogene King's Goal Attainment theory, suggests that human beings are a central focus for nursing practice (Khowaja, 2006). Human interactions, communication, and the attainment of goals are considered fundamental and the core motivators

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of nursing assessment and intervention (Calladine, 1996). Thus, the goal and function of the nursing profession is to promote health, maintain health, and restore health in human beings; to care for the sick, injured, and dying (Khowaja, 2006). By practicing nursing in this way, patients are supported in attaining, maintaining, or restoring health (Calladine, 1996). The basic assumptions included in the theory of goal attainment reinforce the need and purpose for informed decision making, and support the rationale for implementing ACP as a standard of routine health care. It is through the ACP process, that nursing and other health care professionals are facilitating goal attainment in their patients. The fundamental concepts believed to be essential within the theory of goal attainment include perception, communication, interaction, transaction, self, role, growth and development, stressors/stress, time, and space (Khowaja, 2006). The ACP process assists patients in identifying and understanding their own perception of life, health, and illness. By facilitating awareness and acknowledging one's own perception the ACP process can help patients feel autonomous in their quest for goal attainment. The ACP process utilizes communication, interaction, and transaction as tools to help patients grow and development by learning about themselves as autonomous individuals and assist in the identification of individual health care goals. The various concepts and beliefs of King's theory of goal attainment support and warrant the need for the implementation of a standardized process of ACP and will help to provide a framework for the implementation of a formal ACP model for FRWHS.

Patient Advocacy

Today's health care system is changing. Health care consumers and their families desire the right to be adequately informed and to autonomously make decisions regarding their health

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care. Illness and limited knowledge of health care systems and medical interventions often leaves health care consumers feeling vulnerable and powerless (Bu & Jezewski, 2006). Advocating for health care consumers during these vulnerable times is necessary, particularly when someone loses the capacity and power to represent themselves. It is during these times, nurses are ethically obligated to act on the individual's behalf through patient advocacy (Copp, 1986; Seal, 2007). Like caring, patient advocacy is one of the fundamental values of the ACP process. Patient advocacy, which can be viewed as a strategic process, consists of a series of specific and deliberate actions with the goals of preserving, representing, and safeguarding patients' rights, best interests, and values (Bu & Jezewski, 2006). Advocating for the patient includes fostering, protecting and promoting patient well-being, so that they may return to health or achieve a peaceful and dignified death. Advocacy encompasses counseling patients and families so that they may make educated and informed decisions about their care (Seal, 2007).

The philosophies of Curtin, Gadow, and Kohnke have contributed to the conceptual and ethical frameworks of patient advocacy in the current health care model. Curtin's (1979) humanistic philosophy of patient advocacy supports the belief that the humanity of each individual stems forth from all basic human needs. The nurse, as a patient advocate, provides a supportive and therapeutic environment that facilitates the decision making process. According to Curtin, it is through the acts of patient advocacy that nurses assist and support individuals and their families in discovering the significance of their own personal life processes (Hanks, 2005).

Gadow's (1980) philosophy of existential advocacy describes the nurse's role with regard to the facilitation of exercising the individual's right of self-determination. Existential advocacy is based on the principle that freedom of self-determination is the utmost fundamental and valuable human right. Gadow asserts that existential advocacy and self-determination should not

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be infringed upon even if the health care professional feels it is in the interest of the health care consumer's health or life to do so (Hanks, 2005; Gadow, 1980). In addition, Gadow's existential advocacy theory emphasizes patient autonomy by asserting that it is in the health care consumer's best interest to make decisions for oneself. It is thus the nurse's responsibility to guide the health care consumer through the decision making process (Hanks, 2005). This can be achieved by assisting the health care consumer to make decisions that are truly reflective of their own personal values and goals.

Similarly, Kohnke (1982) proposed a functional model of patient advocacy, in which the principal beliefs include an individual's right to self-determination, informed consent, and autonomous decision making (Bu & Jeweski, 2006). According to Kohnke, patient advocacy involves informing individuals of the information they will need in order to make informed decisions, supporting the decisions they make, and ensuring that patients understand their right to make decisions (Kohnke, 1980). By incorporating the ACP process into practice, health care professionals act as patient advocates while simultaneously empowering patients to advocate for themselves. Effective and successful patient advocacy, in conjunction with ACP, can produce positive outcomes that lead to the preservation of patient rights including informed consent, autonomous decision making, and result in an overall improved quality of life (Bu & Jeweski, 2006).

In summary, the theories and ethical principles of Jean Watson, Imogene King, Leah Curtin, Sally Gadow, and Mary Kohnke are embedded throughout the philosophies that support the ACP process. The theories of caring, goal attainment, and patient advocacy endorse and reinforce the need for routine ACP, as well as, guide the development and implementation of this SCP. The theoretical and ethical frameworks which support this SCP will help to ensure patient

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rights are honored and help to establish a higher ethical standard of practice for FRWHS. The following section will provide a comprehensive literature review specific to ACP and this SCP.

Literature Review

Although aging, illness, and death are a few of the universal realities for all, our health care system does not adequately address the needs of patients who are chronically ill, or dying. The advancement of technology has prolonged human life, and has unintentionally contributed to the suffering of a myriad of others. Therefore, providing quality care that meets the psychosocial, spiritual, and physical needs of patients and their families has become a front-line challenge for health care systems. Duration of life in concert with quality of life are choices that should be made by individuals themselves. Health care professionals have been able to respect these choices when ACP processes and advance health care directives are used. ACP can be viewed as a staged, ongoing process that assists individuals and their families in understanding their health conditions, potential future complications, and the implications of those complications. The ACP process incorporates therapeutic communication while providing care for others. ACP is intended to help individuals and families understand their options for future health care and treatment options as it relates to their health problems (Black and Fauske, 2007). The ACP process facilitates the development of a plan. An advance care plan, often in the form of an advance health care directive, can be utilized to provide the individual care that is consistent with their goals and preferences when they are no longer able to make decisions on their own behalf (Respecting Choices, 2007). The goal of ACP is to help clarify the patient's questions, fears, and values, all of which can impact the patient's quality of life (Phipps, True, & Murray, 2003). In addition, ACP is intended to help health care consumers communicate their

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health care wishes and goals to their loved ones and their health care team in the event that they are unable to speak on their own behalf. Most importantly, the process of ACP is intended to ensure that all patients' rights and wishes are respected and honored.

History of Advance Care Planning

Planning for future health care needs is a responsibility that requires time and individualized attention. It is estimated that 50% of patients are not capable of participating in health care decisions at end of life. As a result, the default action by health care professionals is to pursue and implement aggressive and often invasive measures, which can be futile and contribute to a poor quality of life (Respecting Choices, 2007). Efforts to curb these reactions have been addressed by many organizations such as the American Medical Association (AMA), Open Society Institute, and the Robert Wood Johnson Foundation (RWJF). AMA's End-of-Life Care Project, the Open Society Institute's Project on Death in America, and the RWJF's Last Acts Initiative are well established programs developed to enhance end of life care, improve ACP, and increase the utilization of advance health care directives (Martin, Thiel, & Singer, 1999). In addition, efforts to reduce the need for health care professionals to make independent decisions at the end of life were addressed in the Patient Self-Determination Act (PSDA) passed in 1991.

The PSDA aimed to enhance the control individuals had over their own medical decision making, ensure autonomy and self-determination, increase public awareness of advance health care directives, and encourage individuals and families to participate in the ACP process. With this bill, all health care organizations were required to ask adult patients if they had an advance health care directive and inform each patient of their right to accept or refuse treatment. If

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patients did not have an advance health care directive but desired one, it was the organizations responsibility to provide the individual with the information and capability of developing one. In order for these changes to take effect, health care organizations were required to provide staff and community education specific to advance health care directives (Bradley, Blechner, Walker, & Wetle, 1997).

While the PSDA bill remains active today, this information is not routinely provided and is not understood by all health care consumers (Glick, Mackay, Balasingam, Dolan, & Casper-Isaac, 1998). Since the passage of the PSDA in 1991, the prevalence of advance health care directives has gradually increased. A January 2011 data brief published by the Centers for Disease Control (CDC) and Prevention's National Center for Health Statistics reported that advance health care directives for long-term care populations were most common in patients discharged from hospice (88% had an advance health care directive), long term care residents (65% had an advance health care directive), and individuals receiving home health care services (28% had an advance health care directive). Of interest, the study did note that these statistics were different from other studies that did not focus on the long-term care resident population but rather the community at large, which found only 37% of older adults in the community had an advance health care directive (Holley, 2011).

Personal and Monetary Expenditures in ACP

Health care professionals, health care consumers, and society as a whole, need to be informed, knowledgeable, and understand why ACP is important for all adults. ACP is intended for all adults, both healthy and ill (Respecting Choices, 2007). The definition of quality of life varies from individual to individual and thus, individuals need time to contemplate their own

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meanings of quality of life, values, goals, and discuss this information with their loved ones and health care provider when they are healthy (Maxfield et al., 2003).

As health care technology continues to advance, the ability to sustain life artificially increases, and with that, we have the potential to jeopardize quality of life (Duffield & Poszamsky, 1996). As a result of phenomenal technological advances, our nation's populace continues to live longer, and with that, individuals will more than likely experience times where deteriorating health has negative implications for quality of life. For instance, in chronic progressive diseases, deterioration in health can progress over several years. With this comes deteriorating functional abilities, increased dependency on others, and subsequently independence in the home is often compromised (Black & Fauske, 2007). ACP processes address and anticipate the physical, psychosocial, and spiritual needs that can accompany health, illness, and/or injury by anticipating and discussing changes in functional and cognitive health prior to illness progression or an acute crisis (Black & Fauske, 2007).

In addition to respecting an individual's rights and preferences, further concern regarding the necessity to implement ACP for all adults well and ill are important to consider. This includes the unforeseen legal and ethical dilemmas that surround end of life decisions. Sadly, more than 90% of deaths in the United States occur in hospitals or long term care facilities, and not in the comfort of one's own home as preferred. Of those deaths, 80% involve decisions to begin, withhold, or withdraw some kind of health care treatment (Glick et al., 1998). Advance health care directives, often an outcome of the ACP process, have been championed by some as a means of preserving both dignity and autonomy in the face of illness or injury (Thompson, Barbour, & Schwartz, 2003).

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Research has proven that ACP, specifically in end of life care, can reduce unnecessary health care expenditures and improve the quality of life of both the patient and their family members ("Discussions on end-of-life", 2009). Desharnais, Carter, Hennessy, Kurent, & Carter (2007) reviewed several studied that each reported that patients and families that participate in ACP and discuss their care preferences with their health care team feel less anxious and more involved and in control of their health care. In addition, patients perceive that their health care provider has a better understanding of who they are and what their specific health care needs may be.

Timing of ACP

Health care issues, particularly end of life issues, should be discussed while people are in good health. Just as individuals and families prepare for the birth of a child, it is just as important to prepare for illness, injury, and the last chapter of life ("Bringing education", 2008). Carney & Morrison (1997) report that patients believe the most appropriate time and setting for ACP is during a routine office visit when they are in good health and medically stable. Primary care guidelines now recommend that discussions regarding the patient's goals and preferences for present and future health care should occur with all adult patients and be integrated as part of a regular routine preventative visit. Thus, health care professionals will need to educate their patients about ACP and emphasize that this process is a routine and fundamental component of quality care (Maxfield et al., 2003).

It is increasingly beneficial and more effective for patients, their families, and their health care providers to initiate the ACP process before becoming acutely ill. Prior to acute illness or injury, patients have the cognitive capacity and time to devote to thinking about their health care

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goals and preferences. Carney & Morrison (1997) and Glick et al, (1998) reviewed several studies indicating that although patients and families may be aware of advance health care directives and the process of ACP, they want the health care provider that they are most familiar with to be the one to initiate the discussion. Initiation of this discussion when patients are in good health has demonstrated to increase patient participation and collaboration, resulting in patients and families having greater satisfaction with care, increased feelings of control and self determination over health, feelings of enhanced well being, and improvement with treatment plan compliance (Dalton, 2002). Most importantly, these discussions help to ensure that the patient is being cared for, now and in the future, in a manner that is consistent with their preferences (Heiman, Bates, Fairchild, Shaykevich, & Lehmann, 2004).

Challenges and Barriers to ACP

Although recommended, many health care providers, patients, and their families do not discuss health care preferences, particularly preferences with regard to end of life care. The various reasons contributing to the lack of ACP are related to both health care professional and health care consumer identified challenges and barriers. These factors are complex and multi-factorial and include inadequate or lack of ACP education, lack of time and reimbursement, and feeling uncomfortable discussing ACP topics (Respecting Choices, 2007).

Most practicing health care providers have had little formal or structured education and training concerning end of life discussions. Despite some training and hands on experience, many health care providers remain uncomfortable and feel somewhat unprepared and threatened with discussing the topics that are the central focus of ACP. Thus, undertaking ACP discussions is not enthusiastically endorsed by most health care providers and many are reluctant to

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participate (Aronson & Kirby, 2002). Additionally, health care providers have expressed an overall lack of time to invest in such in-depth discussions, stating that ACP is time-consuming and is not a reimbursable service by Medicare, Medicaid, or many private insurers (Duffield & Poszamsky, 1996).

An additional barrier to ACP is that health care professionals strive to help the ill and injured, and therefore, discussions regarding end of life care can represent failure on the part of health care professional and or team (Hospice Management Advisor, 2009). If a health care provider experiences feelings of failure, discussion of end of life topics with patients and families may be avoided or managed poorly (Desharnais et al., 2007). This sense of discomfort has contributed to the low incidence of ACP and advance health care directive formulation in the United States (Duke & Thompson, 2007).

Health care consumers also feel uncomfortable discussing end of life topics. Many view the discussions as irrelevant, and therefore, avoid the discussion. On the other hand, many health care consumers report that they defer ACP as a result of feeling unaware and uninformed of their health care options even though they wish to pursue involvement and planning (Respecting Choices, 2007). Family members are also reluctant to initiate ACP discussions. Often times, family members feel embarrassed about asking questions, or are simply overwhelmed. For many, it is the irrational fear that if you acknowledge the worst-case scenario, it will happen, or, denial that the patient's health condition and prognosis is poor and such discussions should have been addressed much earlier (Desharnais, et al., 2007). Other families have admitted that they do not initiate the conversation because the physician or health care provider did not mention the issue, indicating to them that the topic was not important, relevant, or is off limits ("Discussions

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on end-of-life", 2009). If one or more of these problems occur, the likelihood that effective ACP dialogue will occur is diminished.

Implementing ACP

High quality and routine ACP is necessary and desired, and therefore attention needs to be directed to those individuals that have difficulty addressing such processes. Individuals should either receive assistance to overcome their reluctance or be given guidance and encouragement to refer health care consumers to the appropriate skilled professionals. If the ACP process is delegated to another colleague, it is essential to effectively communicate and coordinate care so that all involved health care providers and team members are aware and fully understand the patient's preferences (Desharnais et al., 2007). This process helps health care professionals to avoid ethical and legal dilemmas by educating patients on end of life care treatment options and opportunities (Glick et al., 1998). However, Heiman et.al (2004) reported that patient-focused interventions, rather than physician-focused interventions were more effective, involved less work by physicians, and were a more feasible option for an entire health care organization. Thus, patient targeted interventions may better assist in ensuring that the process of ACP is not bypassed during primary care office visits. This can be achieved by providing community education. Educating and encouraging health care consumers to initiate the ACP process as early as possible while well, is preferred (Glick et al., 1998).

Effective tools are necessary for implementation of ACP processes. Health care professionals need to be educated, be given opportunities to build confidence and skills, and have easy access to supportive resources to implement ACP processes effectively (Duke & Thompson, 2007). Providing education, training, and developing resource groups who can

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facilitate difficult conversations has proven effective for several organizations (Hospice Management Advisor, 2009). However, health care organizations must understand that to successfully sustain effective ACP programs, education needs to be ongoing, and teamwork, commitment, and continued administrative support are imperative.

Summary

The theoretical frameworks of Watson, King, Curtin, Gadow, and Kohnke have been shown to be embedded within the ACP process and congruent with the purpose of this SCP. In addition, the synthesis of literature simultaneously provides an overview of ACP, and reinforces the need for routine ACP in our health care system. The following chapter will discuss this SCP evidence-based design and methodology, and will provide the reader with a detailed description of the project timeline and utilization of resources.

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CHAPTER III

The following chapter will provide an overview of this SCP design and methodology. A description of the project timeline and the resources utilized for this SCP will be discussed.

Project Design

This SCP was developed and implemented using a descriptive research design with quantitative research methods. The SCP examined two groups of participants. The first group of participants were examined prior to the implementation of the educational intervention of this SCP. The second group of participants were examined following the implementation of the educational intervention of this SCP. The purpose of the examination of the two groups was to evaluate if the intervention elicited change.

Honoring Choices Minnesota

In 2009, administrative personnel and health care professionals from FRWHS established a multidisciplinary ACP advisory committee with the strategic vision to develop, initiate, and implement an effective and sustainable formal ACP model within the ambulatory care setting. In July 2009, FRWHS enrolled in the Honoring Choices Minnesota ACP collaborative with support from Fairview Corporate. Honoring Choices Minnesota is a collaborative, community-wide public health initiative, which enrolled six well established Minnesota health care organizations (Fairview Ridges Hospital, HealthEast, Fairview Oxboro Clinic, HealthPartners, Fairview Red Wing Health Services, Hennepin County Medical Center, Fairview Eagan and Rosemount Clinics) with the shared vision to increase ACP awareness and education, and to implement a standardized comprehensive process of ACP statewide.

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Twin Cities Medical Society and the East Metro Medical Society Foundation serve as the sponsoring, coordinating, and convening bodies for Honoring Choices Minnesota. The Honoring Choices Minnesota collaborative emerged from the relationship between the Twin Cities Medical Society, Respecting Choices Gundersen Lutheran Advance Care Planning team, and the six committed Minnesota health care organizations. The Honoring Choices Minnesota collaborative was initiated and developed with the goal to mirror the Respecting Choices formal ACP model through Gundersen Lutheran Medical Foundation in La Crosse, Wisconsin. Honoring Choices Minnesota utilizes and adapts the principles and training of Respecting Choices, with Minnesota-specific governance, forms, and patient education resources. The need for this initiative throughout FRWHS was described in Chapter 1 (page 12-15).

Respecting Choices

Respecting Choices is an internationally recognized, evidence-based ACP model. Respecting Choices began in 1991, when leaders of the major health care organizations (Gundersen Lutheran and Franciscan Skemp) in La Crosse, Wisconsin began collaborating on the development of an improved model of end-of-life care. The Respecting Choices directors utilized an integrated systems approach that used printed educational materials, videos, and assistance from trained staff to educate health care professionals and the community of the importance and need of ACP. This approach soon became a routine standard of care for the involved health care organizations. After two years of implementation, the Respecting Choices ACP model revealed significant implications on end of life planning in Wisconsin. The processes, lessons, and clinical skills learned from the La Crosse experience have been developed and implemented into a comprehensive curriculum that is now formally known as

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Gundersen Lutheran's Respecting Choices Organization & Community Advance Care Planning Course. Respecting Choices mission is to assist organizations and communities worldwide in enhancing ACP awareness, education, and implementation of ACP practices that support informed health care decisions. As innovators and leaders in ACP education, systems change and development since 1991, Respecting Choices has provided educational training, formal consultation, and resource materials to organizations and communities around the world (http://respectingchoices.org/about_us).

FRWHS and Honoring Choices Minnesota

Formal education, training, and certification for members of the FRWHS ACP advisory committee occurred between July and November 2009 under the expert direction of the Respecting Choices, Gundersen Lutheran Advance Care Planning Model directors. In collaboration with Honoring Choices Minnesota and the FRWHS ACP advisory committee, the Primary Investigator (PI) of this SCP implemented a pilot study that incorporated the development and initiation of a formal ACP model within FRWHS in January 2010. The patient population for this SCP was chosen as a result of the PI's role as the FRWHS Palliative Care clinical provider. This descriptive SCP was developed to address the inadequate utilization and standardization of ACP for individuals and families referred to the FRWHS Palliative Care program and to evaluate the following question:

1) Will the implementation of a formal ACP model increase the utilization and standardization of ACP by all FRWHS health care professionals for patients with chronic disease or advanced illness that are being referred to the FRWHS Palliative Care program?

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Methodology

Institutional Review Board (IRB) applications were submitted to and approved by Saint Catherine University (SCU). An application was also submitted to Fairview IRB; however, after review Fairview identified the SCP as a quality improvement initiative, thus, IRB approval from Fairview was not indicated.

An electronic medical record (EMR) audit of individuals that were referred to the FRWHS Palliative Care program was performed in July 2010. This EMR audit was referred to as the no intervention EMR audit as the formal ACP model and educational interventions had not been implemented at the time of the referral to Palliative Care for this group of individuals. As the Palliative Care clinical provider, the PI had access to the EMRs of those individuals who have been referred to and/or enrolled in the FRWHS Palliative Care program. EMRs between January 1, 2010 and June 30, 2010 were audited to determine the utilization of the ACP process prior to the system wide implementation of the Honoring Choices Minnesota initiative. In addition, the no intervention EMR audit was intended to evaluate the ACP documentation practices within the FRWHS EMR. The PI was responsible for the development of the EMR audit tools and the collection of all data (Appendix B, D). The EMR audit tools were strategically developed with the purposeful intent to evaluate and incorporate the various areas within the EMR that advance care planning issues have the potential to be documented and stored. The EMR audit tool items illustrate that the EMR is multifunctional and complex with the documentation, storage, and retrieval of ACP issues. The audit items 1) Documentation of a Primary Care Provider (PCP) and 2) Documentation of a chronic disease or advanced illness were assessed as they are a requirement upon referral to the FRWHS Palliative Care program.

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The following documentation was collected:

1) Documentation of Primary Care Provider (PCP),
2) Documentation of Chronic Diagnosis or Advanced Illness,
3) Name Header Indicating an Ordered Code Status in EMR,
4) Demographics Indicating Advance Health Care Directive in EMR,
5) Code Status Documentation in Demographics Section of EMR,
6) Narrative Notes in Free Text field of Demographics Section documenting ACP related issues,
7) Scanned Advance Health Care Directive in Encounters Tab of EMR,
8) Documentation that ACP addressed in Ambulatory Setting,
9) Documentation that ACP addressed during last hospitalization at FRWHS,
10) Documentation that ACP addressed by Referring Health Care Professional,
11) Referral for ACP Facilitation

Initiation of the formal ACP model began with development and dissemination of organization wide electronic announcements to communicate FRWHS's involvement with Honoring Choices Minnesota (Appendix E). Following this announcement of intent, the PI developed educational materials to support health care professionals at FRWHS in the ACP process. Curricular development and instruction was facilitated by previous attainment of the ACP facilitator certification received through Honoring Choices Minnesota and Respecting Choices.

The educational content was presented in the form of power point presentations with accompanying lecture and supplemental handouts (Appendix J). The objectives of the educational presentations included: 1) Understand the Honoring Choices Minnesota Initiative at Fairview Red Wing Medical Center;, 2) Define ACP and understand that ACP is a standard of

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routine health care, and; 3) Understand the benefits of ACP and the burdens associated with not participating in ACP. In addition to the power point, lecture, and supplemental handouts, FRWHS health care providers and health care professionals that attended the educational offerings were provided standardized scripts to facilitate ACP discussions with patients (Appendix C). These scripts were adapted from Carney & Morrison (2007) by the PI for use at FRWHS. The adapted script was entitled "Provider Script for Initiating the Topic of Advance Care Planning" for FRWHS. Further, facilitation of ACP as a routine practice was supported with development and dissemination of guidelines and policies that communicate the FRWHS formal ACP model.

In addition to educating health care professionals, community education was needed. To facilitate community education, FRWHS specific Honoring Choices Minnesota brochures, business cards, and posters were created and strategically placed around FRWHS with the intent to increase ACP awareness and educate health care consumers and their families about ACP processes (Appendix G-I). The educational interventions were implemented in July and August 2010.

Following the education offerings, a second EMR audit was completed. EMRs of patients' referred to Palliative Care between September 1, 2010 and February 1, 2011 were reviewed and compared to data retrieved January 1, 2010 to June 30, 2010. This EMR audit was referred to as the with intervention EMR audit as the audit was conducted on EMR's of individuals whom were referred to Palliative Care following the implementation of the educational interventions and formal ACP processes. The purpose of the with intervention EMR audit was to determine if the educational interventions were effective in increasing the utilization of ACP in the FRWHS Palliative Care program. In addition, the with intervention EMR audit

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was utilized to evaluate if the interventions were effective at facilitating standardized documentation for ACP in Palliative Care.

Statistical analysis of the data began and concluded in May 2011 with the assistance of a professional statistician. The hired statistician, a College of Saint Catherine Alumna, has a Master of Science degree in Health Services Research and Policy, and a minor in statistics. To ensure confidentiality, all patient information was de-identified. The results are reported in Chapter 4 and implications for practice are discussed in Chapter 5.

Utilization of Resources

As an organization, FRWHS utilized several internal and external resources to implement a formal ACP model. These resources were also utilized to implement this SCP. Fairview Corporate, with their continued guidance and support, initiated the collaborative relationship between FRWHS and Twin Cities Medical Society with the intent that FRWHS would participate in the Honoring Choices Minnesota collaborative. The Honoring Choices Minnesota collaborative emerged from the relationship between the Twin Cities Medical Society, Respecting Choices Gundersen Lutheran Advance Care Planning team, and the six committed Minnesota health care organizations. As members of the Honoring Choices Minnesota collaborative, all participating organizations now have an established relationship with the Twin Cities Medical Society and The Respecting Choices Gundersen Lutheran Advance Care Planning team. These relationships are invaluable to the success of each organization's initiative. Internal resources included administrative support, the ACP advisory committee (members included: administrative organizational development, physician champion, palliative care nurse practitioner, spiritual health chaplain, senior patient advocate coordinator), certified ACP facilitators (palliative care nurse practitioner, senior patient advocate coordinator, senior patient

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advocates, social workers, nurses, chaplains, and bereavement coordinators), informational technologists and marketing staff. The external resources utilized included the health care professionals, guidance, education, and resources from Honoring Choices Minnesota, Twin Cities Medical Society, and Respecting Choices. A professional statistician was utilized for the statistical analysis of the results of this SCP.

Summary

In conclusion, this chapter provided an overview of the SCP design, methodology, and implementation plan. A timeline of events and resource utilization were also discussed. The following chapter is intended to provide a discussion specific to the results of the SCP.

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CHAPTER IV

This descriptive SCP was developed to address the inadequate utilization and standardization of ACP for individuals and families referred to the FRWHS Palliative Care program. It was intended that, upon completion of this SCP, identification of whether the initiation of a formal ACP model increased the utilization and standardization of the ACP process for individuals with chronic disease or advanced illness referred to the FRWHS Palliative Care program. This chapter will provide the reader with the results of this SCP.

Data Analysis

No intervention and with intervention EMR audit tools were developed and used to evaluate the use of ACP for individuals referred to the FRWHS Palliative Care program. A total of 36 participants were included in this SCP. Twenty-one participants were included in the no intervention group and 15 participants were included in the with intervention group.

Sample

No Intervention Population

Demographic information for the no intervention group is as follows. A total of 21 individuals were referred to the FRWHS Palliative Care program between January 1, 2010 and June 30, 2010. Of the 21 individuals, 19% (N=4) were referred to Palliative Care by their Primary Care Provider (PCP), 38% (N=8) by Skilled Nursing Facility staff, 19% (N=4) by a family member, 5% (N=1) by Home Care staff, 14% (N=3) by Assisted Living Facility staff, and the remaining 5% (N=1) by Partners in Aging staff. Nineteen percent (N=4) were male and 81% (N=17) were female. Ten percent (N=2) of the individuals were between the ages of 50-60.

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Five percent (N=1) of the individuals were between the ages of 60-70. Ten percent (N=2) of the individuals were between the ages of 70-80. Thirty-eight (N=8) percent of the individuals were between the ages of 80-90 and 38% (N=8) between 90-100 years of age. All 21 individuals referred to the FRWHS Palliative Care program had a minimum of one chronic health condition or advanced illness documented in their EMR. Of the 21 individuals referred, 57% (N=12) resided in a Skilled Nursing Facility, 14% (N=3) resided in a private home, and 29% (N=6) individuals resided in an Assisted Living Facility.

With Intervention Population

Demographic information for the with intervention group is as follows. A total of 15 individuals were referred to the FRWHS Palliative Care program between September 1, 2010 and February 1, 2011. Of the 15 individuals, 13% (N=2) were referred to Palliative Care by their PCP, 53% (N=8) by Skilled Nursing Facility staff, 6% (N=1) by a family member, 20% (N=3) by Partners in Aging staff, and the remaining 6% (N=1) by Hospice staff. Forty percent (N=6) of the individuals were male and 60% (N=9) were female. Seven percent (N=1) of the individuals were less than 50 years of age. Seven percent (N=1) of the individuals were between the ages of 50-60. Thirteen percent (N=2) of the individuals were between the ages of 70-80. Fifty-three percent (N=8) of the individuals were between the ages of 80-90. Twenty percent (N=3) of the individuals were between 90-100 years of age. All 15 individuals referred to the FRWHS Palliative Care program had a minimum of one chronic health condition or advanced illness documented in their EMR. Of the 15 individuals referred, 60% (N=9) resided in a Skilled Nursing Facility and the remaining 40% (N=6) resided in a private home.

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A professional statistician was hired for statistical analysis of the data. Initial analyses were performed to determine statistical differences between the no and with intervention groups. Differences between the no intervention and with intervention groups were considered statistically significant if the calculated *p* value was less than 0.05.

For purposes of this SCP, a two tailed t-test was used to determine if the no intervention group and the with intervention groups differed with respect to participant age. Of the 21 participants in the no intervention group, the mean age was 83.9. The mean age of the 15 participants in the with intervention group was 81.3. These results were not statistically significant (p=0.565). These results are displayed in Table 1 (page 44).

A chi-square test was used to determine significance in gender differences and place of residence of the participants. Nineteen percent (N=4) of the 21 no intervention group participants were male and 81% (N=17) were female. Forty percent (N=6) of the 15 with intervention group participants were male and 60% (N=9) were female. These differences were not statistically significant (p=0.156). These results are displayed in Table 1 (page 44).

Place of residence for no intervention and with intervention participants included: Assisted Living Facilities, Skilled Nursing Facilities, or private homes. Twenty-nine percent (N=6) of the 21 no intervention group participants resided in an Assisted Living Facility, 57% (N=12) resided in a Skilled Nursing Facility, and 14% (N=3) resided in a private home setting. Sixty percent (N=9) of the 15 with intervention group participants resided in a Skilled Nursing Facility and 40% (N=6) resided in a private home setting. The differences in the no and with intervention groups on place of residence were significantly different (p=0.037), indicating statistical significance. These results are displayed in Table I (page 44).

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Table I: Demographic Characteristics

	No Intervention (N=21)	With Intervention (N=15)	
	Mean (SD)	Mean (SD)	*p* Value
Age in Years	83.9 (12.3)	81.3 (13.)	0.565
Male	19%	40%	0.166
Place of Residence			
Assisted Living Facility	29%	0%	
Skilled Nursing Facility	57%	60%	*0.037**
Private Home	14%	40%	
Significant difference from baseline (P<.05)			

In addition to basic demographic data, the EMR audit tools evaluated the use of ACP and ACP documentation practices. Data on the following documentation was collected:

1) Documentation of Primary Care Provider (PCP),

2) Documentation of Chronic Diagnosis or Advanced Illness,

3) Name Header Indicating an Ordered Code Status in EMR,

4) Demographics Indicating Advance Health Care Directive in EMR,

5) Code Status Documentation in Demographics Section of EMR,

6) Narrative Notes in Free Text field of Demographics Section documenting ACP related issues,

7) Scanned Advance Health Care Directive in Encounters Tab of EMR,

8) Documentation that ACP addressed in Ambulatory Setting,

9) Documentation that ACP addressed during last hospitalization at FRWHS,

10) Documentation that ACP addressed by Referring Health Care Professional,

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11) Referral for ACP Facilitation

Comparisons were analyzed using a t-test to examine proportions. A t-test was utilized, as it was hypothesized that the with intervention rates would be greater than the no intervention rates as a result of the interventions. Differences between the no intervention and with intervention groups were considered statistically significant if the calculated *p* value was less than 0.05. All results are displayed in Table II (page 47).

All subjects (100%, N=36) had a designated Primary Care Provider (PCP), and a minimum of one chronic disease or advanced illness documented in their EMR. Nineteen percent (N=4) of the no intervention participant's EMRs indicated that a code status had been ordered by a health care provider simply by viewing the name header across the top of the EMR, in comparison to the 33% (N=5) of the with intervention participant's. These results were not statistically significant (p=0.361).

In the no intervention group, 62% (N=13) of the participants had documentation in the demographics section indicating that an advance health care directive was on file. Fourteen percent (N=3) had a code status documented. None (N=0) of the no intervention group participants had any narrative notes specific to ACP in the free text field in the demographics section of the EMR. In the with intervention group, 47% (N=7) of the participants had documentation indicating an advance health care directive was on file. Twenty percent (N=3) of the participants had documentation indicating a code status was on file. Thirty-three percent (N=5) of the with intervention group participants had narrative notes specific to ACP in the free text field in the demographics section of the EMR. Documentation indicating a retrievable advance health care directive was on file was not found to be statistically significant (p=0.374). The documentation indicating the presence of a retrievable code status was not found to be

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statistically significant (*p*=0.640). Whereas, statistical significance was identified specific to higher rates of documentation of narrative notes in free text field in the demographics section following the intervention (*p*=0.008).

Data was collected on the percentage of participants that had a copy of their advance health care directive scanned into their EMR. In the no intervention group, 48% (N=10) of the participants had a retrievable scanned document, compared to 60% (N=9) of the with intervention participants. These results were not statistically significant (p=.483).

Ambulatory care visit notes were also reviewed for documentation of ACP discussions. In the no intervention group, 19% (N=4) of the participants had an ACP discussion with a health care provider during an ambulatory care clinic visit, compared to 60% (N=9) of the with intervention group. These differences were statistically significant (*p*=0.012).

Inpatient admission, progress, and discharge notes were reviewed to evaluate the presence of ACP in the hospital setting. In the no intervention group, 43% (N=9) of the participants had ACP addressed by a health care professional during their last hospitalization, compared to 53% (N=8) of the with intervention group. These results were not statistically significant (*p*=0.558).

Lastly, documentation of whether a discussion about ACP had been held between the patient and referring health care professional prior to and/or upon referral to Palliative Care was evaluated. Nineteen percent (N=4) of the no intervention group participants had documentation of an ACP discussion in their EMRs compared to 33% (N=5) of the with intervention group participants. These results were not statistically significant (p=0.361). There were no referrals to a certified ACP facilitator for individuals referred to the FRWHS Palliative Care program

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following implementation of the formal ACP model during the above specified with intervention study time frame. These results are summarized in Table II.

Table II: Electronic Medical Record (EMR) Audit Items

	No Intervention (N-21)	**With Intervention (N=15)**	***p* Value**
Documentation of Primary Care Provider (PCP)	100%	100%	N/A
Documentation of Chronic Diagnosis or Advanced Illness	100%	100%	N/A
Name Header Indicating an Ordered Code Status in EMR	19%	33%	0.361
Demographics Indicating Advance Health Care Directive in EMR	62%	47%	0.374
Code Status Documented in Demographics Section of EMR	14%	20%	0.640
Narrative Notes in Free Text field of Demographics Section documenting ACP related issues	0%	33%	*0.008**
Encounters Tab: Scanned Advance Health Care Document in EMR	48%	60%	0.483
Documentation that ACP addressed in Ambulatory Setting	19%	60%	*0.012**
Documentation that ACP addressed during last hospitalization at FRWHS	43%	53%	0.558
Documentation that ACP addressed by Referring Health Care Professional	19%	33%	0.361
Referral for ACP Facilitation	N/A	0%	N/A
Significant difference from baseline (P<.05)			

In summary, two of the eleven EMR audit items (Narrative notes in free text field of demographics section documenting ACP related issues and documentation that ACP addressed in ambulatory setting) were significantly higher after the implementation of the formal ACP

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model and educational training. Although only two EMR audit items were statistically significant, all but one item (Demographics indicating advance health care directive in EMR) had higher rates following implementation of the formal ACP model. In addition, referral to a certified ACP facilitator was measured at the with (post) intervention period only, as this intervention was not available prior to the implementation of the formal ACP model.

Summary

In conclusion, this chapter provided an overview of the results of this descriptive SCP. The discussion of these findings and implications for practice will follow in Chapter 5.

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CHAPTER V

The following chapter will provide a discussion of the results of this SCP and a review of the perceived and actual return on investment will be reviewed. Ethical considerations and limitations of this SCP will be identified. Recommendations for future practice will conclude the chapter.

Discussion of Findings

FRWHS believes that improving quality care, enhancing education, and providing comfort through the process of ACP, will help meet the goal of honoring the wishes of patients and families in times of hardship. It was anticipated that the initiation and implementation of a formal ACP model throughout FRWHS would help to ensure compliance with ethical and legal requirements, and would provide patients and families with support, informed consent, autonomy, patient advocacy, and human dignity. This SCP was developed to identify whether or not the initiation of a formal ACP model, including education, access to certified ACP facilitators, and a systematic referral process would enhance the utilization and standardization of the ACP process for individuals with a diagnosis of chronic disease or advanced illness that are referred to the FRWHS Palliative Care program.

Documentation Findings

Prior to the implementation of the formal ACP model and educational offerings, ACP was not implemented as a routine standard of practice at FRWHS and as a result standardized documentation was lacking. The FRWHS EMR has several snapshots and fields in which a health care professional can document ACP related issues, conversations, and can scan advance

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health care directives into the patients EMR (Appendix M-P). Documentation was collected on the following EMR fields:

1) Documentation of Primary Care Provider (PCP),

2) Documentation of Chronic Diagnosis or Advanced Illness,

3) Name Header Indicating an Ordered Code Status in EMR,

4) Demographics Indicating Advance Health Care Directive in EMR,

5) Code Status Documentation in Demographics Section of EMR,

6) Narrative Notes in Free Text field of Demographics Section documenting ACP related issues,

7) Scanned Advance Health Care Directive in Encounters Tab of EMR,

8) Documentation that ACP addressed in Ambulatory Setting,

9) Documentation that ACP addressed during last hospitalization at FRWHS,

10) Documentation that ACP addressed by Referring Health Care Professional,

11) Referral for ACP Facilitation

The implementation of a formal ACP model demonstrated statistically significant positive changes in both the narrative notes field and the documentation that ACP was discussed in the ambulatory care setting for those individuals referred to the FRWHS Palliative Care program. The with intervention EMR audit results indicated health care professionals addressed the topic of ACP in the ambulatory care setting and utilized the narrative notes free text field in the demographics section more following the educational interventions.

Although only two of the eleven EMR audit items were statistically significant, it should be noted that all but one item (Demographics indicating advance health care directive in EMR) had higher rates post intervention (Table II, page 47). These findings indicate an overall higher

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incidence of documentation of ACP related issues for patients referred to the FRWHS Palliative Care program. The findings of this SCP are specific to patients referred to the FRWHS Palliative Care program and not an indication of system wide improvements in incidence of ACP documentation. However, it is important to acknowledge that an increase in the incidence of ACP documentation does not equate to a standardized documentation process, as the data has demonstrated.

The EMR audit items were chosen as key indicators of ACP use in the Palliative Care program at FRWHS for specific purposes. One way in which the audit items assisted the PI in identifying the needs of the system included allowing examination of the EMR system functionality. In an ideal world, the EMR is a tool to facilitate the storing of health care related information. It is intended that the EMRs functionality contributes to an efficient and productive health care team while maintaining an accurate and standardized medical record. However, the complexity of some EMRs can create a more cumbersome documentation process and can result in negative implications for processes such as ACP.

The findings of this SCP EMR audit revealed significant implications for the FRWHS Palliative Care program and the use of the EMR for ACP purposes. Additionally, these findings illustrate that the FRWHS EMR is multifunctional and has the capability to facilitate the communication and storage of ACP information, however, a more streamlined approach is needed.

Subsequently, the PI, in collaboration with FRWHS Information Services (IS) staff and the Honoring Choices Minnesota Initiative, implemented a system wide policy and procedure change for ACP documentation for FRWHS. The system wide goal focused on streamlining and standardizing the EMR documentation of ACP processes and advance health care directives.

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FRWHS IS specialists consulted with the FRWHS ACP advisory committee to assist with the modification of the existing EMR documentation, storage, and retrieval system. The FRWHS EMR was modified to facilitate the standardization of ACP documentation practices and retrieval of ACP related issues, including documents. These modifications are described next and are illustrated in Appendices M-P.

Prior to the Honoring Choices Minnesota collaborative, the retrieval of an advance health care directive and/or other ACP related documents was a tedious and often times an unsuccessful task. If an advance health care directive was scanned into the EMR, the only way to review and/or retrieve the document would be by searching for the document under the encounters tab. Depending on the individual's history, the number of encounters within their EMR could be a few to several hundreds of encounters. For the document to be retrievable under the encounters tab, the health care professional scanning the document in to the EMR would have had to create an encounter for the document. If an encounter was not created for the scanning of the document, the documents may be more difficult to locate and/or not be retrievable at all. As a result of the Honoring Choices Minnesota collaborative, FRWHS IS specialists in conjunction with the PI and FRWHS ACP advisory committee developed and implemented a "media" tab within the EMR (Appendix M). The media tab is a universal location in which all patient level documents, such as ACP documents are stored within the EMR. As a result of this modification, all ACP documents can be reviewed and/or retrieved by means of selecting the media tab, rather than searching through the encounters tab.

In the FRWHS EMR, the presence of a code status documented in the name header indicates that a code status has been electronically ordered by a health care provider (Appendix N). When a code status is electronically ordered and signed by a health care provider, the code

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status is simultaneously documented in the name header and in the demographics section by processes of the EMR (Appendix N). Prior to the Honoring Choices Minnesota collaborative, if a code status was electronically ordered, a chronological listing of present and past code statuses with the corresponding dates, times, and ordering health care providers could be reviewed by selecting the code status in the name header. FRWHS IS specialists in conjunction with the PI and FRWHS ACP advisory committee modified the ACP information that was retrievable by means of the FRWHS EMR name header. As a result of this modification, when the code status is selected for review on the name header, the chronological listing of present and past code statuses with the corresponding dates, times, and ordering providers can be reviewed, in addition to a link to all scanned advance health care directives and power of attorney documents (which are scanned into the media tab). This modification in the FRWHS EMR allows for all ACP related information to be reviewed and retrievable from one universal location within the EMR (Appendix O). Eliminating multiple documentation sites reduces error on part of the health care professional and helps to assure that the patient's wishes and goals will be respected as a result of documentation availability.

In the demographics section of the EMR, there is a narrative free text field located beneath the code status field. This free text field sits adjacent to the power of attorney and advance health care directive fields. Prior to the Honoring Choices Minnesota collaborative, health care professionals were able to free text additional ACP information in this field per their discretion. However, as the advance care plan changes, the health care professional that implements such changes would need to update the narrative notes as the narrative notes free text field would not automatically update according to the new orders. The free text narrative box was not a standardized documentation practice for all FRWHS health care providers, and

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therefore, not all health care providers would look at or update the free text narrative field on a routine basis. Since the Honoring Choices Minnesota collaborative, FRWHS IS specialists in conjunction with the PI and FRWHS ACP advisory committee disabled the narrative notes free text option in the EMR (Appendix P). Now, narrative comments can only be included when a code status is ordered. As a safe guard to ensure the narrative comments are updated as code statuses change, previous comments are simultaneously deleted if and/or when a new code status is activated. This EMR modification helps to ensure that all ACP documentation is simultaneously updated and consistent with the patient's health care goals and wishes.

Standardizing ACP documentation practices in the EMR is one way FRWHS can facilitate the incorporation of ACP into routine health care. If the ACP documentation processes are standardized, more efficient, and less cumbersome, FRWHS health care professionals will be more inclined to incorporate the processes into routine practice. To help ensure the ACP wishes of patients and families are honored, the FRWHS health care team must make diligent efforts to standardize and update ACP documentation practices now and in the future. Although FRWHS ACP documentation efforts have improved since the implementation of the formal ACP model, the documentation inconsistencies do remain. It is anticipated that future EMR revisions will be necessary in an effort to continue to meet the needs of the ACP process, health care professionals, and health care consumers.

Place of Residence Findings

Red Wing, Minnesota is home to an aging population. According to a study by the State of Minnesota, the number of people in Minnesota over age 65 will double between 2005 and 2030. It is estimated that by the middle of that time frame there will be more retirees in

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Minnesota than there are school age children (www.redwing2020.org). Advancing age is often coupled by health deterioration and increased health care needs. Health care consumer's place of residence is often dictated by their health status and health care needs. By incorporating the process of ACP, Palliative Care has the potential to improve quality of life for individuals and families that are confronted with health deterioration, increased health care needs, chronic disease or advanced illness. Although Palliative Care is not a new philosophy of care or specialty of medicine, many individuals, families, and health care professionals are not knowledgeable of the concepts or services. Lack of Palliative Care and ACP awareness can negatively affect referral to, accessibility, and utilization of Palliative Care and ACP services. Individuals and families who are confronted with chronic disease or advanced illness reside in various settings throughout the community. Therefore, it is imperative that individuals and families from all community settings have knowledge and accessibility to Palliative Care and ACP services. Although place of residence was not initially captured during the initial collection of data, it was found to be statistically different between groups when the demographical data was analyzed (p=0.037). As noted in Chapter 4, the no intervention group participants resided in all three residence settings. In contrast, the with intervention group participants resided in Skilled Nursing Facilities and private homes. The absence of Palliative Care referrals from patient's residing in an Assisted Living Facilities is of concern. This finding has significance for FRWHS and its ACP efforts, along with the health care consumers in the Red Wing community.

FRWHS strives to meet the health care needs of the whole community. To remain in harmony with this mission, FRWHS must continue modifying ACP efforts to meet the needs of the organization and community. ACP is appropriate for all adults and is particularly beneficial

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for individuals with a chronic disease or advanced illness. Patients and families that are in need of, or would benefit from, such services must have knowledge of, and equal accessibility to such services. The lack of Palliative Care referrals from all residential settings along the health care continuum in Red Wing may be indicative of a lack of awareness of, or equal accessibility to ACP services. To enhance education and facilitate equal accessibility to ACP services, FRWHS ACP advisory committee continue to provide certified ACP facilitator training to health care professionals and community members. The individuals trained as certified ACP facilitators work and/or volunteer in various health care and residential settings throughout the Red Wing community. It is imperative that FRWHS continue to focus strategic planning efforts to enhance access to ACP services to meet the needs of the evolving community.

Return on Investment

As an organization, FRWHS has always been committed to providing quality care to their community. Positive patient outcomes and patient experiences reflect this commitment. The implementation of a formal ACP model into routine practice provides patients and their families with the higher quality of care. Routine exposure to the ACP process has the ability to enhance the comfort levels of both health care professionals and the community. Historically, many health care providers and professionals at FRWHS have had difficulty addressing ACP topics with their patients. The difficulties identified included comfort level, knowledge of the ACP reimbursement, and time expenditure. Health care is costly and has physical, psychological, and financial implications that effect patients, families, health care organizations, and society as a whole. The physical, psychological, and financial implications of implementing ACP prior to a health care crisis have the potential to be astronomical. These issues were taken into

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consideration by the ACP advisory committee when developing a formal ACP model for FRWHS. The ACP advisory committee determined it would be beneficial from both time and financial expenditures to train non-physicians as the certified ACP facilitators.

The role of the certified ACP facilitator is multi-factorial. The certified ACP facilitator has several responsibilities including educating patients and families about ACP and the involved processes; engaging patients and families in in-depth ACP discussions; assisting others in understanding the importance of ACP and advance health care directives; and facilitating in the development of thorough and accurate advance health care directives. In addition, certified ACP facilitators are responsible for helping the community understand the local ACP practices and materials, which will in turn increase the effectiveness of the established ACP model. The facilitators have dedicated time to devote to in-depth and comprehensive discussions. With the ACP facilitators, FRWHS health care providers now have the ability to refer patients and their families to individuals who have had additional education, training, and certification in ACP and have devoted time built into their daily workflow to have in-depth ACP discussions with patients. However, even though certified ACP facilitators are being utilized, it remains the health care provider or PCP's responsibility to initiate the topic of ACP with their patients and revisit the topic on a routine basis.

In addition to the inclusion of ACP facilitators, the initiation of the formal ACP model has the power to reduce the barriers of health care providers (lack of ACP education and knowledge, financial and time expenditure constraints, and comfort levels). Making these changes helps to facilitate adherence to the vision, missions, and values of FRWHS. Lastly, initiation of this formal ACP model has the potential to create greater job satisfaction for the

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FRWHS team, enhance patient satisfaction, reduce health care costs, and ultimately contribute to higher quality of care for the community.

Recommendations

Routine ACP benefits the physical, psychological and financial well-being of health care consumers, families, health care organizations, third party payers, and society as a whole. Earlier referenced studies illustrated the system and community wide benefits of routine ACP. These studies help to facilitate the implementation of formal ACP models as a standard of care into health care systems.

ACP is recommended as a routine standard of care for all adult patients. The processes necessary to implement and sustain a successful ACP model are multifactoral. First and foremost, stakeholder buy-in by means of increasing ACP awareness and knowledge is essential. Educating health care professionals and community members about the benefits and implications of routine ACP is fundamental. The implications for patients who do not have adequate ACP necessitate mandatory education for all health care professionals on process, procedure and follow up. In addition, health care professionals must strategically focus community educational efforts on ACP, just as they do illness and injury prevention.

In an effort to facilitate the implementation of routine ACP into clinical practice, the processes and procedures for implementation must be clear, concise, methodical, and standardized. Communication of such processes needs to be disseminated to all stakeholders to facilitate the implementation and utilization of routine ACP across the continuum of health care. Documentation of such processes must be standardized and universal within health care organizations. Creating documentation procedures that are standardized, clear, and concise will facilitate compliance with recommended ACP documentation practices. Standardizing ACP

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documentation has the potential to reduce inadequate ACP practices. In an attempt to reduce documentation inconsistencies and improve the availability of advance care plans, all efforts should be focused to establish standardized documentation procedures, including a universal location within the EMR for all ACP documentation. Once the universal ACP documentation location within the EMR is established, it will be imperative to educate all the appropriate health care professionals how to utilize the documentation tools and instruct them as to what the documentation expectations will be. Being multifunctional, the EMR should act as a tool to facilitate the ACP process. Health care professionals should utilize EMRs to their fullest capabilities. EMRs have the advanced capability to remind health care professionals to initiate ACP. Automatic triggers can and should be built into the EMR to create a health maintenance reminder for the health care professional to initiate ACP processes. By creating ACP health maintenance triggers within the EMR, ACP will be incorporated into the routine practice of all health care professionals.

As a health care system, we must empower all health care professionals to incorporate ACP into their practice. Doctorally prepared Advanced Practice Registered Nurses (APRN) are in unique leadership positions to increase awareness, enhance education, and facilitate the development and implementation of formal ACP models throughout the health care system. This SCP serves as a call to doctorally-prepared APRNs to continue to educate all health care professionals and consumers of the countless benefits of ACP and act as a vehicle to facilitate the implementation of ACP into routine health care.

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Study Limitations

No study is without limitations. The small sample size of this SCP was determined solely on the basis of referral. The small and heterogeneous sample size (N=36) of this SCP is a limitation. The findings are highly subject to Type II errors as a result of a small sample size. Limited sample size, as well as non-comparable pre and post intervention groups can result in inaccurate results and thus impact the power of a study (Melnyk & Fineout-Overholt, 2005). Ideally, one would be able to generalize the results of a study to a larger population. Unfortunately, the results of this SCP cannot be generalized to larger systems in that this project was implemented within a single department of a smaller sized health care organization. The results of this SCP are not indicative of system wide results.

According to research and previously conducted studies, effective and successful interventions specific to ACP include, but are not limited to educational forums, formal policies and procedures, automatic referral triggers built within the EMR, as well as, supplying referring health care professionals that are uncomfortable initiating the topic with standardized scripts and resources to facilitate discussion (Heimann et al., 2004). It was anticipated that the educational interventions would not reach all of the health care providers at FRWHS. In an effort to disseminate the education to all the health care providers, the educational forums were intended and developed as a mandatory learning activity with continuing medical education credits available for attendees. Attendance was mandatory for inpatient staff and strongly encouraged for the remaining FRWHS staff. Attendance of the educational offerings was poor and therefore contributed to the limitations of this study. In an effort to disseminate the ACP educational materials across FRWHS, electronic learning modules will be assigned as mandatory learnings via the FRWHS learning management system (LMS) at a later date. The electronic learning

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modules, collaboratively developed by the PI, the FRWHS ACP advisory committee, and FRWHS education specialists are available for review in Appendices K & L.

Additionally, ACP policies and procedures were not formalized at the organizational level during this SCP. Rather, policies and procedures involving the implementation of the formal ACP model were communicated to FRWHS staff through administrative announcements and emails (Appendix E). To address this contributing limitation, the FRWHS ACP advisory committee, in collaboration with the PI, are initiating formal ACP policies and procedures that are in the process of being implemented at the organizational level. These will be disseminated throughout FRWHS upon final administrative approval.

Lastly, a limitation of the evaluation of intervention effectiveness includes not evaluating whether or not community interventions were helpful in increasing the awareness, satisfaction or utilization of ACP by community members. For purposes of future study, it would be beneficial to evaluate if the community interventions were effective with regards to increasing knowledge, patient satisfaction, and utilization of ACP in community members.

Ethical Considerations

As a health care system, FRWHS had ethical and legal obligations to standardize and incorporate the process of ACP into the delivery of practice. FRWHS believed that improving quality care, enhancing education, and providing comfort through the process of ACP, would help meet the goal of honoring the wishes of patients and families in times of hardship. As a result of the lack of ACP standardization, the implementation of a formal ACP model was deemed ethically necessary at FRWHS. A collaborative relationship with Honoring Choices Minnesota was established in conjunction with the interventions of this SCP to help ensure FRWHS provides care that is congruent with ethical and legal recommendations. This SCP

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consisted of the development and initiation of a formal ACP model, EMR audits, and educational interventions. The implementation of a formal ACP model and the educational interventions of this SCP did not have an effect on the participants of this study. Thus, this SCP had minimal to no harm or risk to the study participants. Participant protection and confidentiality were considered with utmost priority. This SCP was implemented with the hope to facilitate a higher standard of ethical practice throughout FRWHS.

Conclusions

The findings of this SCP did not have statistically significant findings for FRWHS as a whole. However, the findings of this SCP do suggest implications that can improve future ACP practices for FRWHS, other organizations, and society. Further research is necessary to determine what factors caused and/or contributed to the results of this SCP. Future research has the potential to contribute to a wealth of information by further investigating 1) gender and place of residence differences with respect to referral to Palliative Care, and 2) what factors caused and/or contributed to a lower documentation rate indicating an advance health care directive was on file within the EMR. The findings of this research would assist in providing invaluable insight into referral, accessibility, utilization, and documentation practices of Palliative Care and ACP services.

In conclusion, ACP has many implications for health care today. Routine ACP benefits the physical, psychological, and financial well-being of health care consumers, families, health care organization, third party payers, and society as a whole. As technology continues to advance, and health care consumers live longer with multiple complex co-morbidities, the implementation of ACP as a routine standard of practice is imperative. Although evidence exists that demonstrates the benefits of routine ACP, continued research is necessary.

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APPENDICES

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APPENDIX A

June 1, 2010

Jessica Ann Hinkley-Reese, RN, CNP
634 Willers Court
Lake City, MN 55041

Re: IRB#10-EXP-23 Standardization of an Advance Care Planning Model

Dear Ms. Hinkley-Reese:

Thank you for your prompt reply to the St. Catherine University Institutional Review Board (IRB) letter of 5-13-10 outlining the stipulations required for approval of the research project listed above. You have addressed all concerns and clarifications as requested. As a result, your project has been approved.

Please note that all research projects are subject to continuing review and approval. You must notify the IRB of any research changes that will affect the risk to your subjects. You should not initiate these changes until you receive written IRB approval. Also, you should report any adverse events to the IRB. Please use the reference number listed above in any contact with the IRB. This approval is effective for one year from this date. If the research will continue beyond one year, you must submit a request for IRB renewal. At the end of the project, please complete a project completion form. These forms are available on the St. Catherine University IRB website.

If you have questions or concerns about these stipulations, please feel free to contact me by phone (X 7739), email (jsschmitt@stkate.edu), or campus mail (mail stop MPLS). We appreciate your work to ensure appropriate treatment of your research subjects. Good luck with your research.

Sincerely,

John Schmitt, PT, PhD
Chair, Institutional Review Board

Cc: Emily Nowak, PhD, RN

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APPENDIX B

No Intervention Electronic Medical Record (EMR) Audit Tool

Patient Initials:___________
Date Referred to Palliative Care:________________
Referred by:_______________

Date Electronic Medical Record (EMR) reviewed for SCP purposes: _____________

Does the patient have a primary provider: Yes No
Documentation of Chronic/Advanced Illness: Yes No Diagnosis:

Does the Name Header on the EMR
indicate there is an Advance Directive on file Yes No

Under Demographics→Clinical Information
Is there documentation that reports that there
is an advance directive Yes No

If so, is the code status documented? Yes No

Are there any notes/dates documented with
regard to conversation? Yes No

Under Encounters or Media Tab
Is there a scanned advance directive document/plan in
the EMR? Yes No

Is there any documented evidence that
advance care planning has ever been addressed Yes No
in the ambulatory care setting?
If so, by whom? Comment:

Last hospitalization, was advance care planning Yes No
addressed?
If so, by whom? Comment:

Upon Palliative Care Referral
Does the referring provider address advance
care planning in their visit note? Yes No

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APPENDIX C

Provider Script for Initiating Topic of Advance Care Planning

(Patient Name), I have found it very important as a health care provider to talk with all of my patients about planning for their future health care in the event that an unforeseen injury or illness were to occur. This is a way for me, as a health care provider, to ensure that my patients are cared for in a way that is consistent with their health care goals and preferences when they might not be able to communicate and make decisions for themselves.

I do not anticipate that anything will happen to you in the near future however, unforeseen accidents and illnesses do occur.

We at Fairview Red Wing Health Services are committed to providing you with the highest quality of care, and most importantly, the care and treatment that you desire.

It is a good opportunity now to begin to contemplate and talk through some of these issues. We refer to this process as advance care planning-which is an organized process of communication that is purposely intended to assist, engage, and support patients, their families, and the involved health care professionals in understanding, reflecting upon, and discussing the individual's goals, values, and preferences for their present and future health care.

As your provider, I would like you and your family to meet with one of our advance care planning facilitators to begin the advance care planning process. This will help us as your health care team, know and understand what your health care goals, values, and preferences are, as well as, how you would wish to be cared for now and in the future.

(Carney & Morrison, 1997)

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APPENDIX D

With Intervention Electronic Medical Record (EMR) Audit Tool

Patient Initials:___________
Date Referred to Palliative Care:________________
Referred by:_______________

Date Electronic Medical Record (EMR) reviewed for SCP purposes: _____________

Does the patient have a primary provider: Yes No
Documentation of Chronic/Advanced Illness: Yes No Diagnosis:

Does the Name Header on the EMR
indicate there is an Advance Directive on file? Yes No

Under Demographics→Clinical Information
Is there documentation that reports that there
is an advance directive? Yes No

If yes, is the code status documented? Yes No

Are there any notes/dates documented
with regard to conversation? Yes No

Is there any documented evidence that
advance care planning has ever been addressed
in the ambulatory care setting? Yes No

Last hospitalization, was advance care planning
addressed? Yes No
If so, by whom? Comment:

Under Encounters or Media Tab
Is there a scanned advance directive document Yes No

Upon Palliative Care Referral
Does the referring provider address advance
care planning in their visit note? Yes No

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Was an order placed for a referral to a certified advance care planning facilitator?	Yes	No	
If yes, did the certified advance care planning facilitator initiate contact with patient	Yes	No	
If yes, was ACP session conducted?	Yes	No	Comment:
Was a plan documented?	Yes	No	

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APPENDIX E

May 7, 2010
From Scott's Desk
· **Honoring Choices Minnesota:** Fairview Red Wing Health Services is participating in *Honoring Choices, Minnesota*, an area-wide initiative to assist and facilitate advance care planning. The current pilot program work group includes Karen Hanson, Jessica Hinkley Reese, Sheryl Voth, Dr. Marc Bettich, Trudi Paulson, Kim Erickson, Teri Johnson, Lorelei Youngs, Carol Mcclelland and Judy Treharne. As part of the initiative, many of the work group members have been certified as advance care planning facilitators to assist patients and families through the process. The work group is now conducting a pilot study with plans to implement a formal model of advance care planning organization-wide in August 2010. Watch for additional information on training opportunities later this year.

July 5, 2010
From Scott's Desk
· **Honoring Choices**: This spring we introduced a new program called *Honoring Choices Minnesota*. Adapted from a program pioneered by Gunderson Lutheran, *Honoring Choices* has several trained facilitators on our staff that are available to work with patients and their families to articulate decisions about end-of-life care. Please plan to attend the upcoming workshops about this important new service. More information is available below.

July 12, 2010
From Scott's Desk
· **Honoring Choices Minnesota:** Advance Care Planning Educational Forums will be offered for all staff on July 15, 30, Aug. 13 and 18 from 12-1 p.m. While the forums are not mandatory, everyone is encouraged to attend to learn more about this important program that will help us better meet the needs of our patients. The forums will last approximately 30-40 minutes with time for questions and discussion. CEU's are available for applicable staff.

October 25, 2010
From Scott's Desk
· **Honoring Choices Minnesota:** Fairview Red Wing Health Services is participating in *Honoring Choices, Minnesota*, a state-wide initiative to facilitate advance care planning as a routine standard of care. Beginning November 1, 2010 you will see several new marketing tools including: Honoring Choices Minnesota Advance Care Planning brochures, business cards and displays throughout our buildings. As we continue to strive for excellence in customer service, we ask your help in building awareness of the advance care planning resources we offer at Fairview Red Wing. Please refer inquiring minds to the Honoring Choices Advance Care Planning phone line 388-4491. Please contact Jessica Hinkley-Reese, Karen Hanson or Sheryl Voth with questions or concerns.

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APPENDIX F

Did you know that Advance Care Planning is a Routine Standard of Care???

The Time Has Arrived…

Our patients want to be involved in their health care decisions!

Do you feel comfortable and prepared to answer questions about advance care planning?

Do you know what resources are available to you, your family and our community?

Honoring Choices: Advance Care Planning

Educational Forums

July 15, 30 August 13, 18

3rd Floor Classroom 12N-1pm

Attend a session to learn about advance care planning, FRWHS efforts to incorporate and standardize advance care planning, our roles and responsibilities, and what resources are available

CEU's Available

Questions: contact Jessica Hinkley-Reese x5642

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APPENDIX G

Honoring Choices Minnesota

Planning today for future health care choices

Health care today seems more complicated than ever. There are more choices than ever before and sometimes in a crisis there is little time to understand those choices or to communicate your wishes. Planning today for health care decisions that may need to be made in the future is called "advance care planning."

Honoring Choices Minnesota is an advance care planning process designed to help you understand health care choices you may face in the future and reflect on such choices in light of your beliefs, values, and goals. The process then involves discussing your choices with loved ones and care providers, and making a plan that fits for you, usually a written document called an *advance directive* that becomes part of your medical record.

Start Planning Today

It's not always easy to begin the conversation about future health care choices, but it's important to that you begin now and take whatever time you need to develop a plan of care. At Fairview Red Wing, trained facilitators are available to help you through the advance care planning process. A direct phone line, **651-388-4491**, allows patients to leave a message for a facilitator who will return the call to schedule a planning session and start the conversation.

What is an advance directive?

An advance directive is a written plan that you make today for health care choices you may face in the future. It usually consists of two main parts: first, you appoint another person or persons you want to make health care decisions for you if you're unable to make your own decisions (health care agent); second, you provide instructions about your preferences for future health care (living will).

Completing an advance directive is optional but it is recommended so that your values and preferences may be clearly communicated to your loved ones and care providers and so that your choices may be followed in the future.

Your planning partners

Honoring Choices Minnesota facilitators work with you, your loved ones and your health care team to understand and respect your choices. Our facilitators will come to you wherever you are, at home, in the hospital or clinic, in a long-term care facility—they will be there to meet your needs.

Our facilitators were trained in the advance care planning process developed by Gundersen Lutheran Health System in LaCrosse, Wisconsin. This process has been successful in helping more patients than ever have clear plans for health care providers to follow.

The best time to develop an advance care plan is now, not when faced with a crisis. To begin the conversation, contact one of our trained facilitators at **651-388-4491** and schedule a planning session

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APPENDIX H

Honoring Choices Minnesota

Planning today for future health care choices

Honoring Choices Minnesota is an advance care planning process designed to help you understand future health care choices and make an advance care plan that respects your choices and becomes part of your medical record. It is a free service, available to anyone.

The best time to develop an advance care plan is now.

To begin the conversation, contact one of our trained facilitators at **651-388-4491**.

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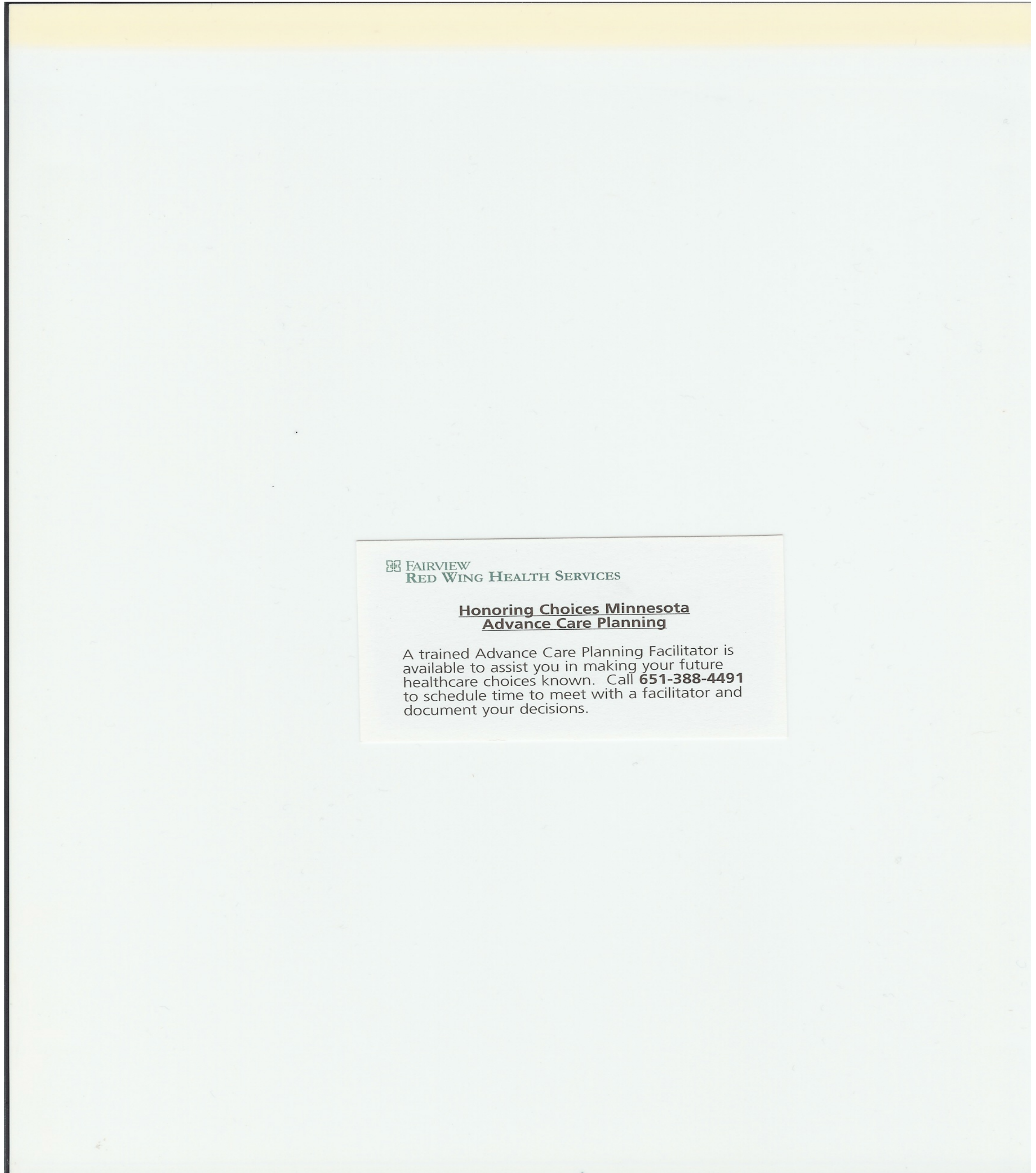
APPENDIX I



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Honoring Choices Minnesota
Advance Care Planning

A trained Advance Care Planning Facilitator is available to assist you in making your future healthcare choices known. Call **651-388-4491** to schedule time to meet with a facilitator and document your decisions.

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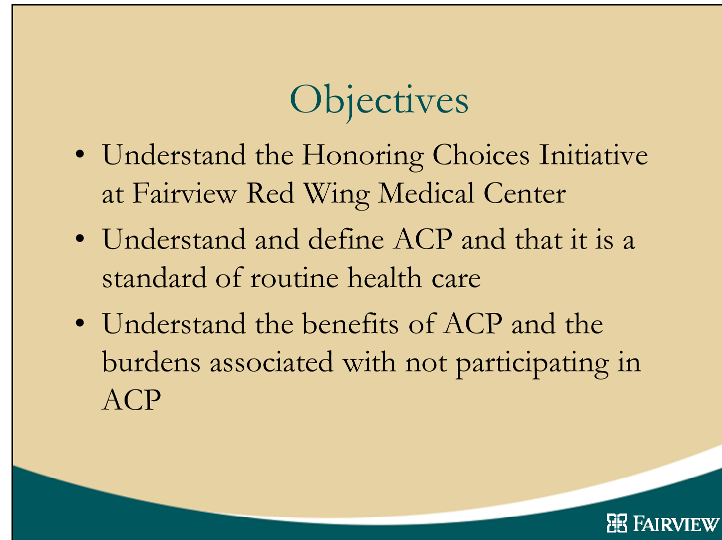
APPENDIX J



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Respecting Choices

- Gundersen Lutheran, LaCrosse, Wisconsin
- 1991-2 health care organizations
  - Gundersen Lutheran
  - Franciscan Skemp
- Initiative Elements:
  - Community engagement
  - Planning facilitation skills training
  - Quality improvement
  - Systems in place to honor patient wishes

2

Respecting Choices

- Model that provides organizations with tools, expertise, resources and proven methodologies that can be utilized to implement a successful ACP program

- Five Promises Model

3

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Respecting Choices

- 1995-1996 study
- Results:
  - 540 decedents eligible for study
    - 8/10 had written AD found in medical record
  - In 98% of the cases, preferences were consistent with decisions made at end of life
  - Of those that had AD, 77% completed a HCPOA.

4

Honoring Choices Minnesota Initiative

- Organized initiative sponsored by East Metro Medical Society
  - 12 different health care organizations
  - Initiative efforts began in 2009
- Collaborative advance care planning project
  - Training and education based upon the Respecting Choices model

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Honoring Choices: FRWHS

- July 2009: Respecting Choices ACP workshop
- November 2009: ACP Training and Certification
  - Met with leadership, providers and managers
- January 2010-June 2010: Pilot
  - Study population and workflow
  - Collaboration with IS and phone line
  - Collaboration with HIM
  - Marketing
    - Posters, fliers, business cards

6

Honoring Choice Minnesota Initiative

- Goal:
  - Complete 80 Advance Care Plans
- Results:
  - 88 individuals contacted regarding ACP
  - 80 facilitations in process
  - 53 completed care plans
  - Baseline: 28% of Fairview Red Wing Health Services patients who died July 2008-Dec. 2009 had an advance care plan at the time of death.

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Advance Care Planning

- Organized process of communication to help an individual understand, reflect upon, and discuss goals, values and beliefs for future health care decisions
- When the process is conducted well…..
- When the process is not conducted well…

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Advance Care Planning

- Staged, ***ongoing*** process of:
  - Assisting individuals in understanding their medical conditions and potential future complications
  - Understanding health care options
  - Discussing choices with family, loved ones and providers
  - Reflecting upon choices in relation to their personal wishes, goals, and values

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Advance Health Care Directive

- Written tool utilized to communicate preferences for future health care decision making should an individual become unable to speak on their own behalf
  - Prevalence of completing AD remains at 25-30%
- Patient Self Determination Act 1991:
  - Requires:
    - all health care institutions to inquire about HCD's upon admission
    - Provide information and education on HCD's

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3 Components of Advance Care Planning

- Understanding
- Reflection
- Discussion

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Understanding

- Understand why ACP is important
- Understand the components of ACP
- Understand what they are planning for
- Understand the benefits
- Understand the consequences of not planning
- Understand health care choices

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Reflection

- Opportunity to reflect upon personal goals, values and beliefs
- Explore fears and concerns
- Describe what living well means
  - Quality of Life
- Explore experiences with loved ones who have been seriously ill

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Discussion

- Encourages individuals to communicate with chosen HC agents, loved ones, and providers
- Focused discussion
- May lead to the development of a written plan
  - Informal plans are also acceptable
  - Discussion is often more important than the document itself

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Barriers to ACP

- Lack of time
- Comfort level
- Fear/Threatened
- Knowledge and attitudes
- Lack of community awareness
- Lack of education and training
- Lack of reimbursement for such discussions
- Health Consumers ? Relevance and need of topic

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Terminology

- **Will:** legal document created by a competent adult to specify how to divide assets and property after death
- **Living Will:** written instructions that tell physicians and family members what life-sustaining treatment one does or does not want at some future time if a person becomes unable to make decisions on their behalf.

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Terminology

- **Power of Attorney**: legal document in which one person gives another the authority to make specified financial decisions and to assume financial responsibilities
- **Health Care Power of Attorney:** legal document a person appoints someone else to make health care decisions in the event that the person becomes incapable of doing so

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Health Care Power of Attorney

- Recommended Qualifications:
  - Can be trusted
  - Is willing to accept this responsibility
  - Is willing to follow the values and instructions you have discussed
  - Is able to make complex, difficult decisions
  - HCPOA cannot act as a witness

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FRWHS Next Steps…..

- Continue staff education
  - Learning Management System
  - Facilitator Training and Certification
    - August 2010-contact Sheryl Voth or Trudi Paulson
- Implement community educational outreach
  - Educational forums
  - Educational posters/handouts
- Continue collaboration with IS and HIM
  - Health maintenance triggers: 55 years old

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FRWHS Next Steps….

- Develop ACP as standard of care
- Improve ACP upon admission to SNF/ALF
- Implement POLST forms

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Your Roles and Responsibilities

- Be knowledgeable of the advance care planning process and that it is a standard of routine health care
  - Share your knowledge with others
- Be knowledgeable of the resources available at FRWHS
  - Advance Care Planning Facilitator Certification
  - Advance Care Planning Facilitation
- Hotline: **651-388-4491**

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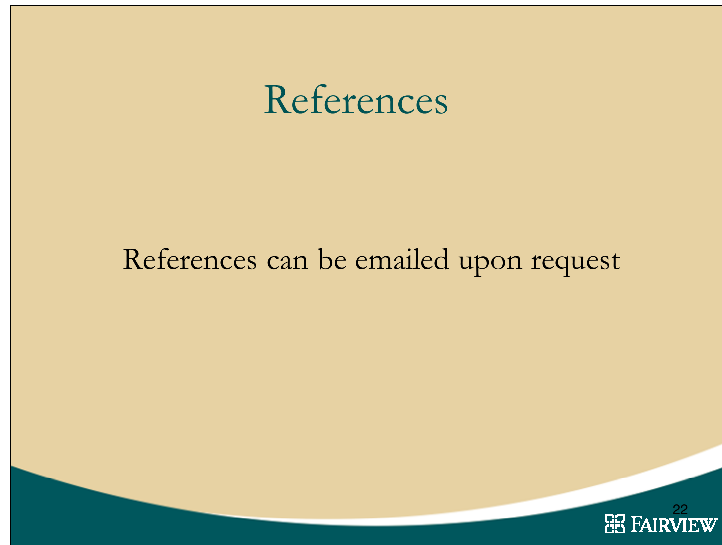

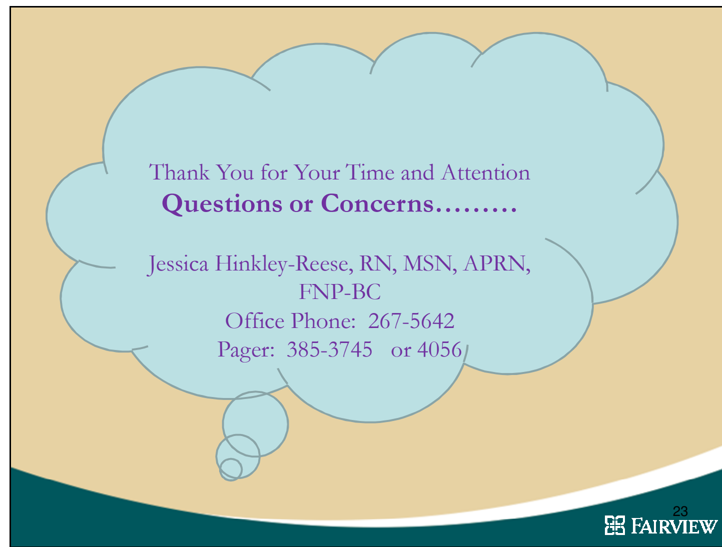

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APPENDIX K

Honoring Choices Minnesota
Advance Care Planning Program:
Understanding Your Role

Fairview Red Wing Health Services

Objectives

- Recall purpose of the Honoring Choices Program.
- Differentiate between the healthcare worker role and the role of the trained facilitator with regard to advance care planning.
- Identify how to locate patient's Advance Care Plan.

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Review

- Goal of an Advance Care Planning Program is to initiate discussion and develop a plan for future health care decision making.
- Advance Care Planning is the ongoing process of:
  - Assisting individuals in understanding their medical conditions and potential future complications
  - Understanding health care options
  - Discussing choices with family, loved ones and providers
  - Reflecting upon choices in relation to their personal wishes, goals, and values

What is your role?

- Over 12 direct patient care staff have been trained as facilitators to meet with patients & their loved ones to help with Advance Care Planning
- ALL staff who have direct patient care have the responsibility to assist patients to begin the Advance Care Planning process.

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Video link

Click here to view a short video to learn how ALL of us have a part in the process of Advance Care Planning

ACP Facilitator Role

- Assist individuals in understanding their medical conditions and potential future complications
- Help individual understand health care options regarding future medical decisions and end-of-life treatment preferences
- Facilitate reflection upon choices in relation to their personal wishes, goals, and values
- Encourage conversation with family, loved ones and providers
- Assist individual in developing a Health Care Directive

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Your Role

- Assist individuals in understanding their medical conditions and potential future complications
- Answer patient/family questions, provide education
- Make appropriate referral for ACP facilitation

Your Role

- To locate patient's Health Care Directive in EPIC – go to Chart review click on Media tab, check the ACP Documents box – look for "Advance Directives"
- Review with patient, if update is needed make referral to Honoring Choices facilitator
- Honor their wishes as stated in Health Care Directive

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Make a referral for ACP

- Share Facilitator phone number (651-388-4491)
- Send Epic message to RW ACP Facilitator pool
- To access Health Care Directive forms (for both MN and WI residents) and for further information, go to the intranet – click on the "For Employees" tab and click on Honoring Choices
- For further information contact Trudi Paulson at 267-5425 or Karen Hanson at 267-5386.

Future

- POLST – This is a Provider Order for Life-Sustaining Treatment. Approved in 2009 by the Minnesota Medical Association, this document will be introduced at FRW later in 2011. The target audience for this form are patients diagnosed with serious illnesses such as those enrolled in hospice programs, living in nursing homes and using home care agencies.

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Summary

- Your role as provider/caregiver is important to success of Advance Care Planning Program at Fairview Red Wing.

(Questions for Post Test)

1. The Advance Care Planning program at Fairview Red Wing Health Services consists of
   a. Receiving information about program, making call, ...
2. True or False The role of the provider/caregiver is to meet with the patient and family with goal of creating advance care plan. False
3. In order to locate/use patient's Advance Care Plan you will need to
4. POLST stands for
   a. Physician's Orders for Life Sustaining Treatment
   b. P

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APPENDIX L

Honoring Choices Minnesota:
An Advance Care Planning Program

Objectives

- Recognize need for Advance Care Planning
- Identify purpose of a Health Care Directive
- Recognize terminology used in Advance Care Planning
- Recall key elements of the advance care planning program, Honoring Choices Minnesota.
- Identify the advance care planning resources available to the individual, their loved ones, and our community
- Identify the role of Fairview Red Wing staff in Advance Care Planning.

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Terminology

Living Will – A directive that spells out the types of medical treatments and life-sustaining measures the patient wants.

Medical Power of Attorney – A legal document that names a person – referred to as a health care agent or proxy–to make medical decisions in the event a patient is unable to do so.

More Terminology

Health Care Directive – this is what we at FRW use in our Honoring Choices program. It consists of two parts: choosing a health care agent and stating treatment preferences.

Do Not Resuscitate (DNR) order - This is a request to not have cardiopulmonary resuscitation (CPR) if the patient's heart or breathing stops. A provider puts this order in the patient's medical chart.

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Still More Terminology

POLST – This is a Provider Order for Life-Sustaining Treatment. Approved in 2009 by the Minnesota Medical Association, this document will be introduced at FRW later in 2011. The target audience for this form are patients diagnosed with serious illnesses such as those enrolled in hospice programs, living in nursing homes and using home care agencies.

The Need for Advance Care Planning

- A woman has had heart problems for years…and her condition is getting worse. She doesn't want to talk about the progression of her disease but says, "don't worry about it. Everything will be fine".
- Upon admission to the hospital a man tells his care giver: "I don't want to die the way my father did. My son knows what that means."
- During a routine physical a patient states, "I really don't see the need to plan for when I am dying. I'm healthy now and have plenty of time later to think about such things."

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Honoring Choices Minnesota

- A state wide initiative to encourage discussion and help people in our community to develop Advance Care Plans.
- It is a *facilitated conversation* and it often results in a *document* called a Health Care Directive
- Key participants
  - All FRW patients—regardless of age or health conditions
  - Patient's designated health care agents, family members
  - Health care team
  - Trained Advance Care Planning (ACP) Facilitators

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ACP Facilitated Conversation

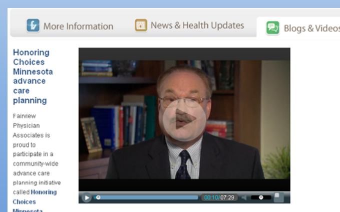
- Staged, ongoing process with goal of initiating discussion and creation of Health Care Directive
  - Assists individuals in understanding their medical conditions and potential future complications
  - Facilitates understanding of health care options
  - Facilitates discussion of choices with family, loved ones and providers
  - Opportunity for reflection about choices in relation to personal wishes, goals, and values
  - Communicating plan to others

Video link

Click here to open the Fairview Physicians page

Then click on Blogs & Video tab to view

Honoring Choices Minnesota advance care planning



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What is my role in Advance Care Planning?

- Encourage all patients to participate in Advance Care Planning
- Share your knowledge with others
- Consider your own Advance Care Planning
- Contact the ACP Facilitator team via:
  - Intranet (under "For Employees" tab)
  - Direct phone line 651-388-4491
  - Epic pool (RW ACP Facilitators)

Summary

- Honoring Choices is an Advance Care Planning Program that includes facilitated conversations between a patient, their loved ones, and their health care team to understand and reflect on future health care choices and to document their preferences, usually in a Health Care Directive.
- A Health Care Directive is a legal document that names a health care agent and lists treatment preferences for health care decisions that may need to be made in the future.

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Forms and Referrals

To learn more about our Honoring Choices Advance Care Planning process and to access resources, go to the intranet, click on "For Employees," then "Honoring Choices"

- To refer a patient to Honoring Choices, have them call the Facilitator phone line to make an appointment: 651-388-4491

(Questions for Post Test)

1. The purpose of an Advance Care Plan is to:
   a.
2. Key elements of Honoring Choices Minnesota include:
   a.
3. Which of the following are NOT Advance Care Planning resources available to our community?
   a.

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APPENDIX M

New Media Tab Snapshot:

Hyperspace - RW HI PARK - FAIRVIEW PRODUCTION - JESSICA H

Zztestrehab,Jethrine V

Female, 53 year old, 01/01/1958 — Patient Type: Potential Special Needs

PCP: KELLY, RYAN PATRICK — MRN: 0029028619 — Primary Cvg: PREFERRED... — MyChart: Active — Code: DNR/DNI

Allergies: Sulfa Drugs, Dust Mite... — Infection: MRS... — Isolation: None

Chart Review

Encounters | Notes/Trans | Laboratory | Imaging | Procedures | ECG | Other Orders | Medications | Episodes | Letters | Misc Reports | Media

5 records loaded, all records loaded

No filters applied

Date/Time	Document Type	Description	Enc Date	File Attached to
03/23/2011 9:59 AM	Advance Directi...	POLST - 3/22/11		Zztestrehab, Jethrine V [0029028619]
12/19/2010 11:43 PM	Clinical Unknown	Lab order : EBNZR	12/07/2007	Rapid Strep [87430.000] [25535670] on 12/7/2007
05/15/2008 10:28 AM	Advance Directi...	Advance Directive		Zztestrehab, Jethrine V [0029028619]
05/15/2008 10:24 AM	Power of Attorney	POA		Zztestrehab, Jethrine V [0029028619]
05/15/2008 10:03 AM	Insurance Card			Zztestrehab, Jethrine V [0029028619]

Media Tab: New Universal Location within EPIC for storage of Patient Level ACP documents

** Jethrine Zztestrehab is a fictitious patient used for purposes of this demonstration

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APPENDIX N

Name Header Code Status Link:

Code Status Link in Name Header

** Jethrine Zztestrehab is a fictitious patient used for purposes of this demonstration

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Code Status: Name Header & Demographics Snapshot

Hyperspace - RW HI PARK - FAIRVIEW PRODUCTION - JESSICA H

Zztestrehab,Jethri... Female, 53 year old, 01/01/1958 Patient Type: Potential Special Needs

PCP: KELLY, RYAN PATRICK MRN: 0029028619 Primary Cvg: PREFERRED... MyChart: Active Code: DNR/DNI

Allergies: Sulfa Drugs, Dust Mite... Health Maintenan... Research: None Infection: MRS... Isolation: None

Demographics

Contact Information | Clinical Information | Additional Information

Pharmacy Preferences: CORNER DRUG (CLINIC - PHARMACY CLOSED) RED WING; WALGREENS - 3142 S SERVICE DR, RED WING; WALGREENS - CORNER DRUG - 401 W 3RD ST, RED WING

Provider: KELLY, RYAN PATRICK — PCP: General

Code status: DNR/DNI Date updated: 9/28/2011

Power of attorney Date asked: 2/21/2006

Advance directive Date asked: 2/21/2006

Context: Outpatient

Permanent comments: HBOC # 12345 HBOC # ***

When Code Status is Ordered: Simultaneously Documents the Code Status in Name Header and Demographics

** Jethrine Zztestrehab is a fictitious patient used for purposes of this demonstration

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APPENDIX O

Name Header Code Status Link:

Report Viewer

Back

Patient Information

Patient Name	Sex	DOB	SSN
Zztestrehab, Jethrine V	Female	1/1/1958	xxx-xx-9999

Current Code Status

Date Active	Code Status	Order ID	Comments	User	Context
9/28/2011 1:29 PM	DNR/DNI	88750940		WINN, DARIN	Outpatient

Code Status History

Date Active	Date Inactive	Code Status	Order ID	Comments	User	Context
9/28/2011 1:28 PM	9/28/2011 1:29 PM	DNR	88750939	Some comments	WINN, DARIN	Outpatient
3/7/2011 8:52 AM	9/28/2011 1:28 PM	Full Code	54676418		KELLY, RYAN	Outpatient
2/1/2011 2:19 PM	2/8/2011 12:10 PM	Full Code	53052866		WINN, DARIN	Outpatient
10/21/2010 10:04 AM	2/1/2011 2:19 PM	DNR	50854427		WINN, DARIN	Outpatient
10/2/2009 1:44 PM	10/21/2010 10:04 AM	DNR	None		WINN, DARIN	Demographics
4/11/2005 2:47 PM	4/11/2005 2:47 PM	None	None	comments	WINN, DARIN	Demographics

Patient-Level Documents:

Scan on 3/23/2011 9:59 AM by Abstractor, K.J : POLST - 3/22/11
Scan on 5/15/2008 10:28 AM by Winn, Darin : Advance Directive
Scan on 5/15/2008 10:24 AM by Winn, Darin : POA

Problem List

Other specified counseling — Advanced directives, counselin
Counseling regarding advanced directives
24 problems were filtered away

Modification: Links to Problem List

Modification: Universal Location links to Documents under media tab

Close

** Jethrine Zztestrehab is a fictitious patient used for purposes of this demonstration

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APPENDIX P

Narrative Notes Field: Free Text Disabled

Hyperspace - RW HI PARK - FAIRVIEW PRODUCTION - JESSICA H

Epic | Home | Multi Sched | In Basket | Chart | Encounter | Addendum | Telephone Call | Refill Enc | Patient Lists | UpToDate | Print | Log Out

Zztestrehab,Jethrine V

Zztestrehab,Jethri... Female, 53 year old, 01/01/1958 Patient Type: Potential Special Needs
PCP: KELLY, RYAN PATRICK MRN: 0029028619
Primary Cvg: PREFERRED... MyChart: Active Code: DNR/DNI
Allergies: Sulfa Drugs, Dust Mite...
Health Maintenan... Research: None
Infection: MRS... Isolation: None

Chart Review
SnapShot
Results Review
Graphs
Growth Chart
Flowsheets
Problem List
History
Letters
Demographics
Order Entry
Immunizations
Allergies
Medications
Forms
Episodes of Care
SmartSet Selector
Health Maintenance
Close Encounter
Visit Navigator
More Activities

Demographics

Contact Information | Clinical Information | Additional Information

Patient Lists

Pharmacy Preferences
CORNER DRUG (CLINIC - PHARMACY CLOSED) RED WING
WALGREENS - 3142 S SERVICE DR, RED WING
WALGREENS - CORNER DRUG - 401 W 3RD ST, RED WING

Lab Preferences

Primary Location:

Provider	PCP type
KELLY, RYAN PATRICK	General

Restricted access | Chart abstracted

Code status: DNR/DNI Date updated: 9/28/2011
Comments:
Context: Outpatient Code Status History
Mark as Reviewed Never Reviewed

Power of attorney Date asked: 2/21/2006
Advance directive Date asked: 2/21/2006

Permanent comments:
HBOC # 12345
HBOC # ***

Restore

Narrative Notes Field: Free Text Disabled

JESSICA H Encounters Future/Standing Orders 8:32 PM

** Jethrine Zztestrehab is a fictitious patient used for purposes of this demonstration

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