Challenges health systems face in accessing AD documents, providing training, and communicating with patients and families

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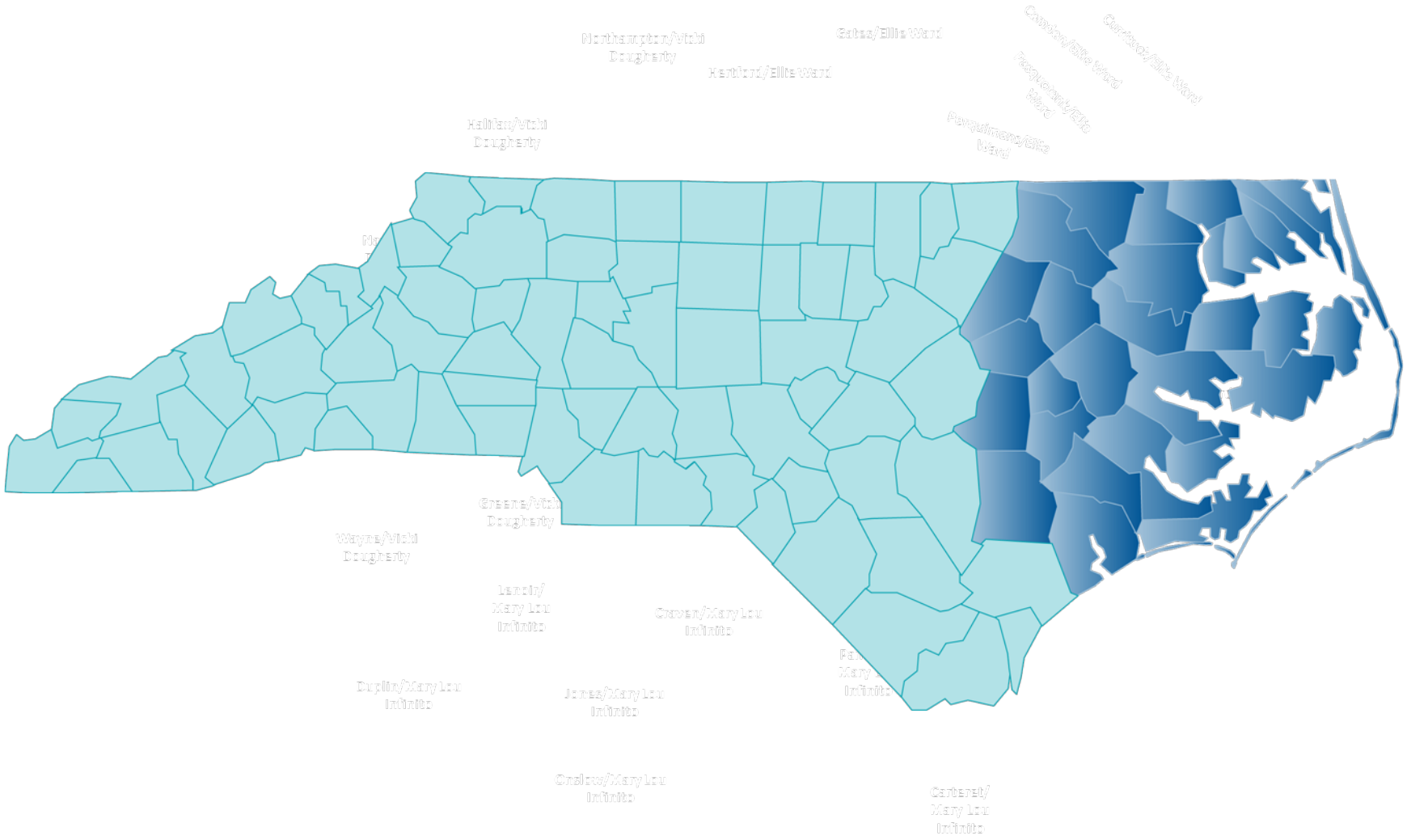
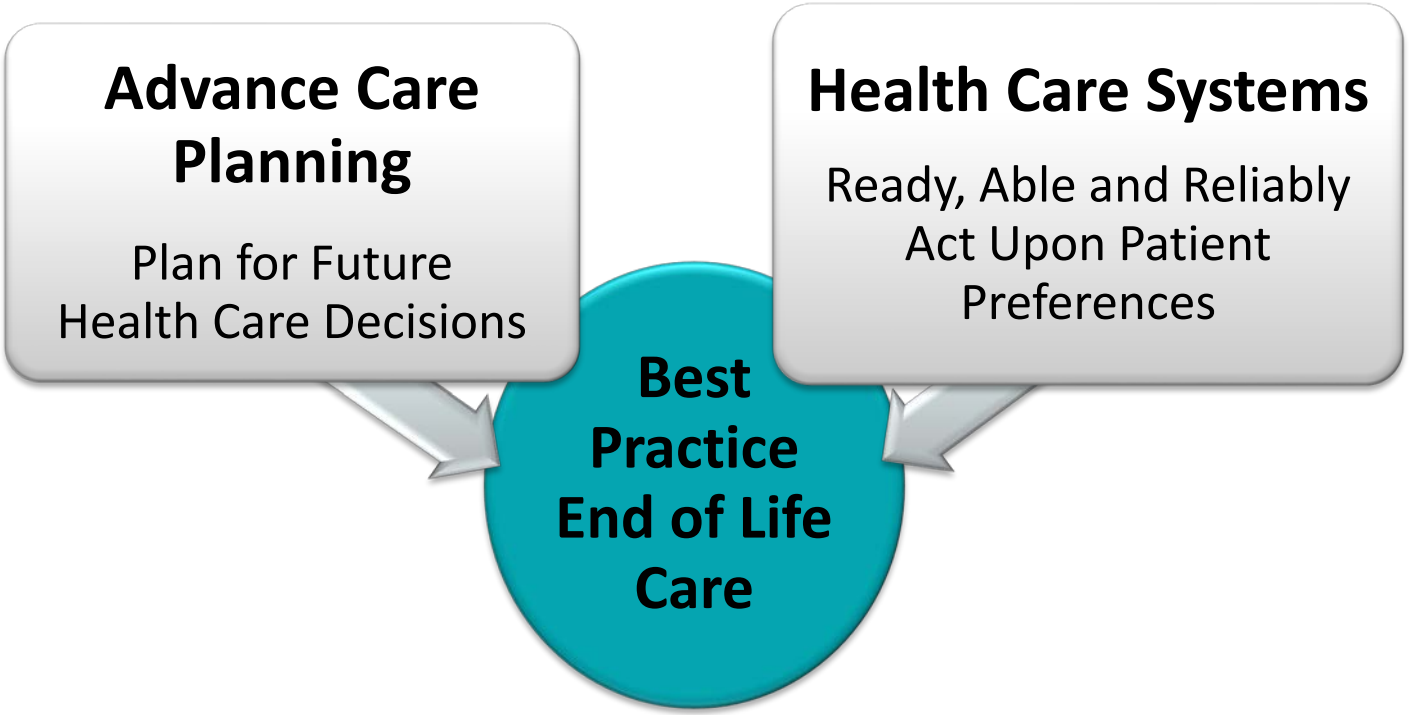
Vidant Health Footprint



Vidant Health Framework



Every adult with an Advance Directive	**Be honest to enable informed choices**
Know what matters to our patients	**Honor and act upon their preferences**

Vidant Health 2019 Work Plan

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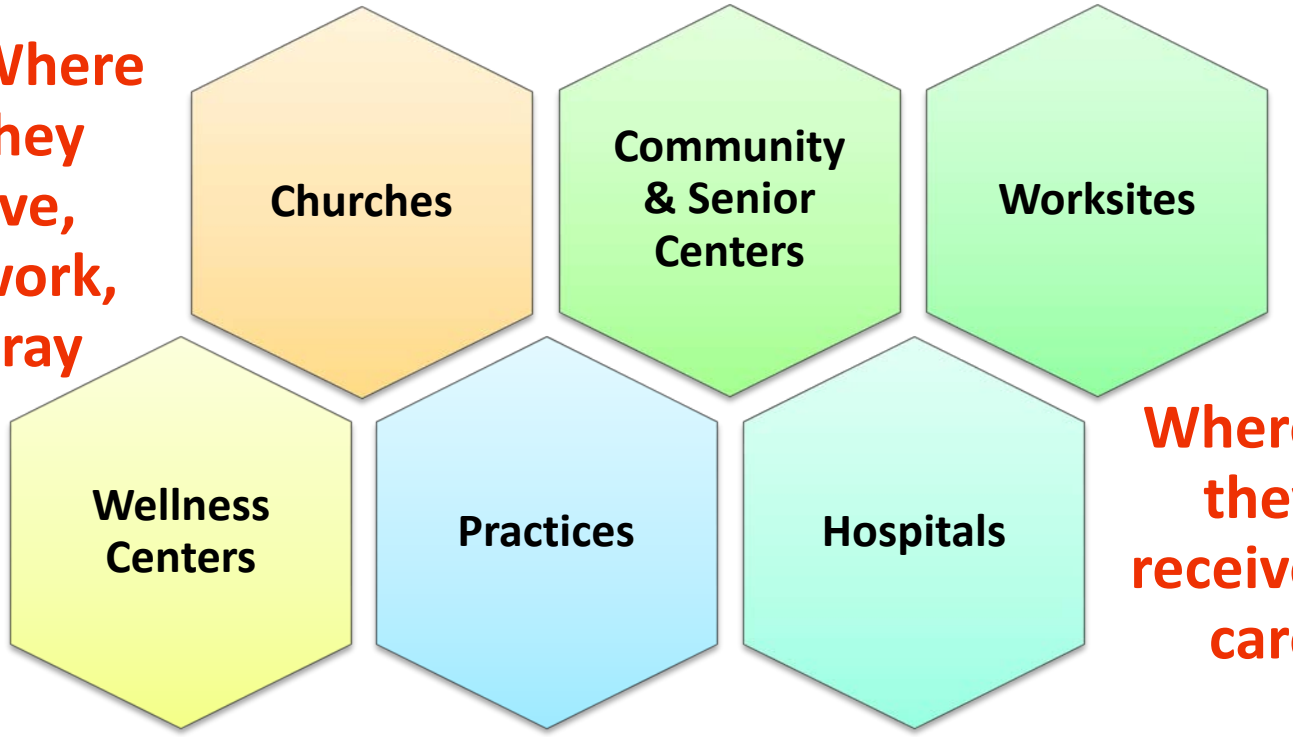
Community ACP Outreach	Team Member Education	Experience	ACP Systems	Analytics	Integrate & Transform Care	Advocacy
• ACP events in faith, community, worksites, hospitals, clinics • 3 Campaigns: Conversation Sabbath, NHCDD, Dying to Know • Marketing enhancements: web content, videos, event referral workflow & marketing	• Secure and launch provider curriculum • ACP in Essentials for Excellence Module • Increase team members trained in ELNEC & Respecting Choices • Serve as regional training center and faculty	• Increase team member participation in HELLO • Explore No One Dies Alone and Death Doula Programs • Monitor experience surveys, complaints & grievances for opportunities and celebrations	• EHR ACP Navigator & Visits – Refine, drive uptake, audit documentation & reimbursement • MyChart revisions • Document indexing workflow audit • Complete EOL/ACP Policy Review	• Drill down capability of Advance Directive Metric • Team Member ACP Measure via CIN • Establish EOL Scorecard	• We're Listening innovations • Increase ACP in service lines • Support Palliative Care development for regional hospitals and outpatient • Develop EOL strategies for population health • Collaboratives to improve transitions and portability of MOST/DNR	• State & National leadership & collaboration: TCC Board, NCHA, NCPCC, NCIOM Palliative Care Task Force, Premier, Respecting Choices Advisory • Legislative Agenda

Community engagement

Past 3 Years: 850 Events- 15,537 Participation- 1000 AD Scanned in Community
FY 2018: 347 Events 10,578 Participation 281 AD Scanned in Community $300K Community Benefit

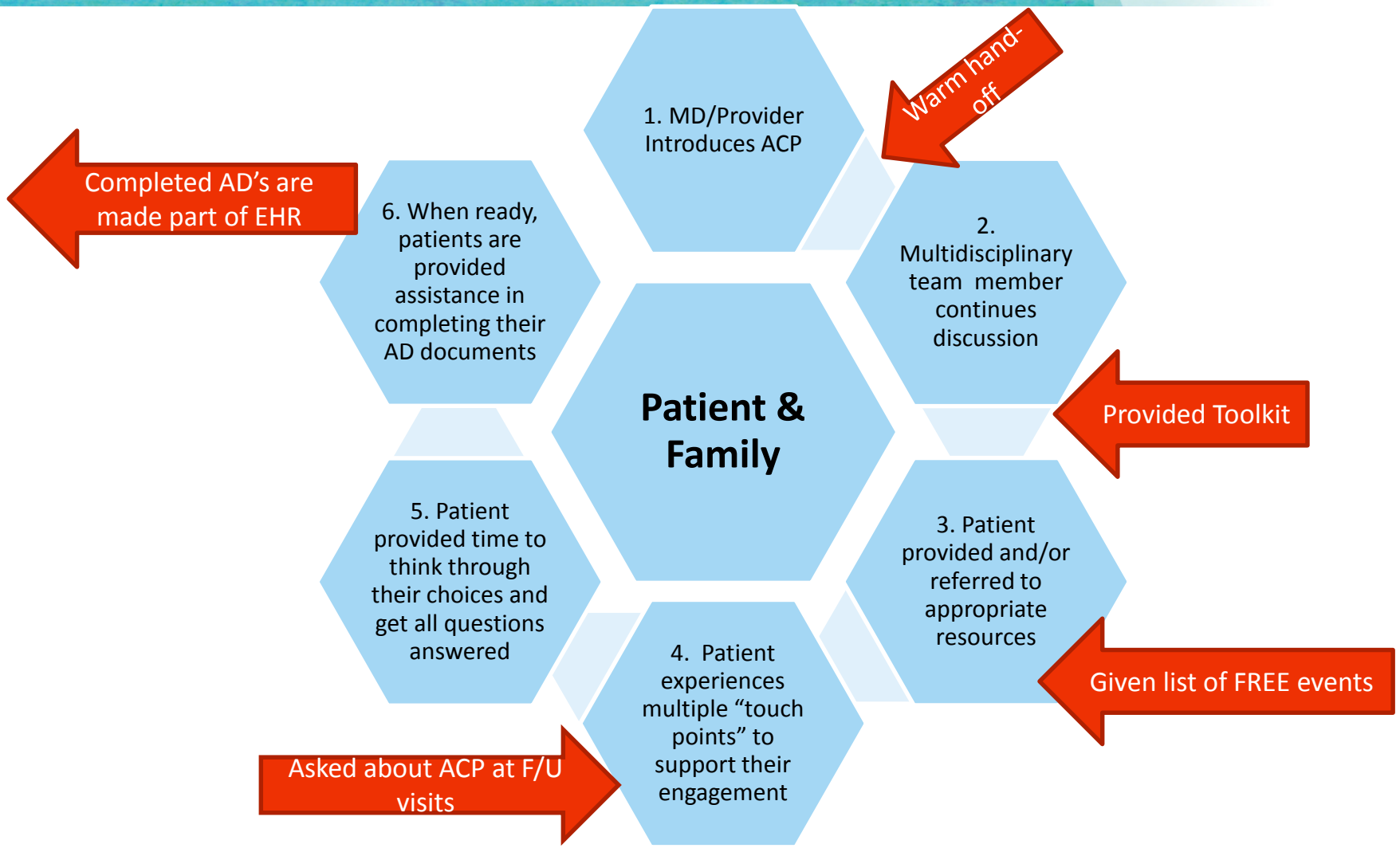
Engaging Consumers in Advance Care Planning & Completion of Advance Directives

Where they live, work, pray



Where they receive care

Desired state



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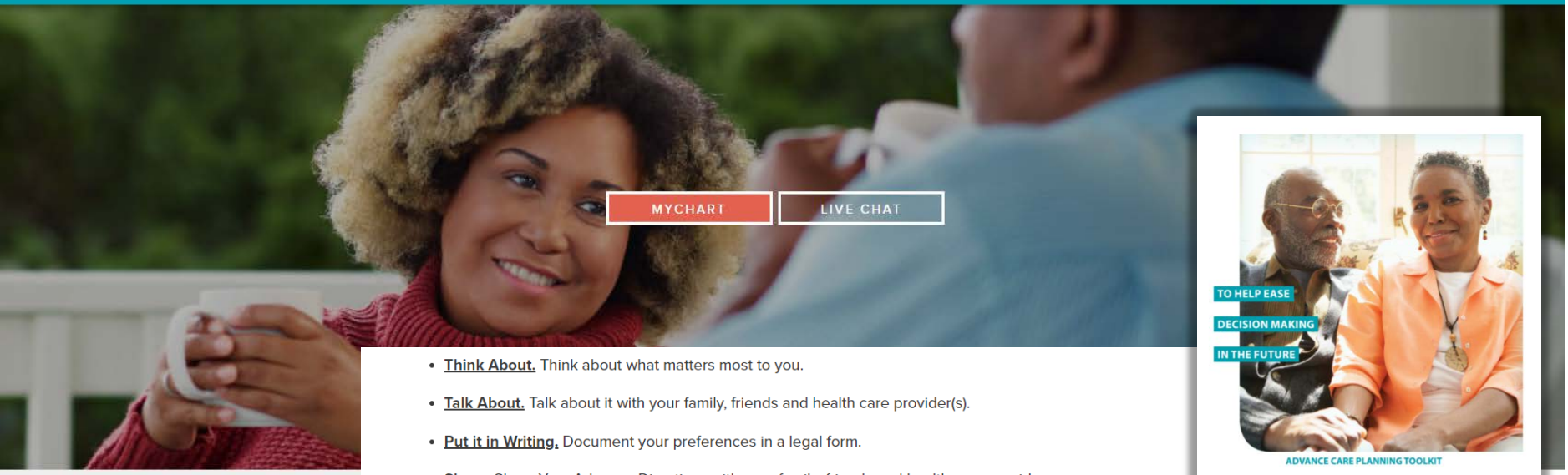
MYCHART PAY MY BILL Search

Find a Doctor | Manage My Health | Services & Treatments | Patients & Families | Locations & Directions | Referring Physicians



Manage My Health

Advance Care Planning

- **Think About.** Think about what matters most to you.
- **Talk About.** Talk about it with your family, friends and health care provider(s).
- **Put it in Writing.** Document your preferences in a legal form.
- **Share.** Share Your Advance Directives with your family, friends and health care providers.
- **Review.** Review your documents periodically, but at least annually.

DOWNLOAD THE TOOLKIT

DESCARGUE LA GUIA

ADVANCE INSTRUCTION FOR MENTAL HEALTH

If you are interested in becoming a facilitator for advance care planning, **please download this information packet** and follow the registration instructions.

Watch the short instructional video below from Legal Aid of NC to walk you step-by-step through completion of the Toolkit.

Challenges related to accessing AD documents

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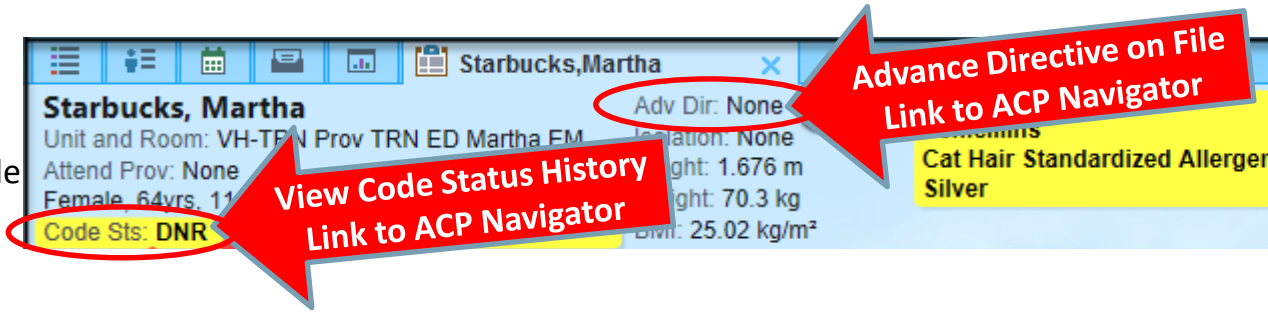
Epic re-design

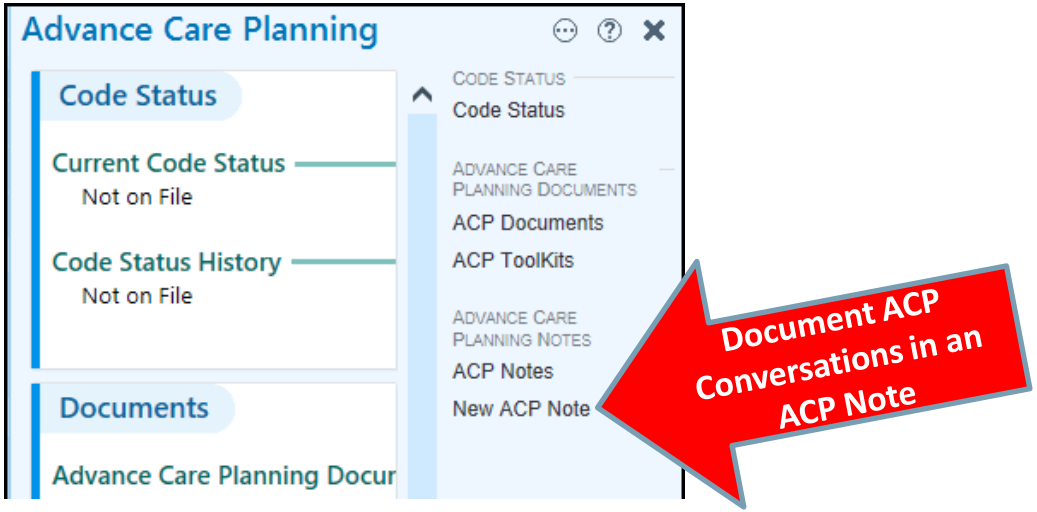
Header:

- Quick Check Code Status
- Quick Check if Advance Directive on File
- Hyperlink to ACP Navigator



ACP Navigator:

- View Code Status History
- View Advance Directives - Current & History
- View ACP Notes across Inpatient & Ambulatory
- Add ACP Note - ANYONE!
  - Provider, Case Manager, SW, RN, Chaplain.
  - If you have an ACP Conversation – Document It!




Still
a long
way
to go
Kids!

Not the time to check the EHR

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What if…


NORTH CAROLINA
DRIVER LICENSE
SAMPLE
4d DLN 123456789123
3 DOB 08/15/1957
4b EXP 08/15/2020
1 DOE
2 JANE
8 1100 NEW BERN AVENUE
RALEIGH, NC 27697-000
Designation of AD on file
9 CLASS C
9a END NON
12 RESTR NONE
15 SEX F
18 EYES BRO
16 HGT 5'-10"
19 HAIR BRO
RACE
Jane Doe
4a ISS 08/15/2015
5 DD 1234567890
08/15/57
VETERAN
Current organ donor designation

Challenges related to ACP training

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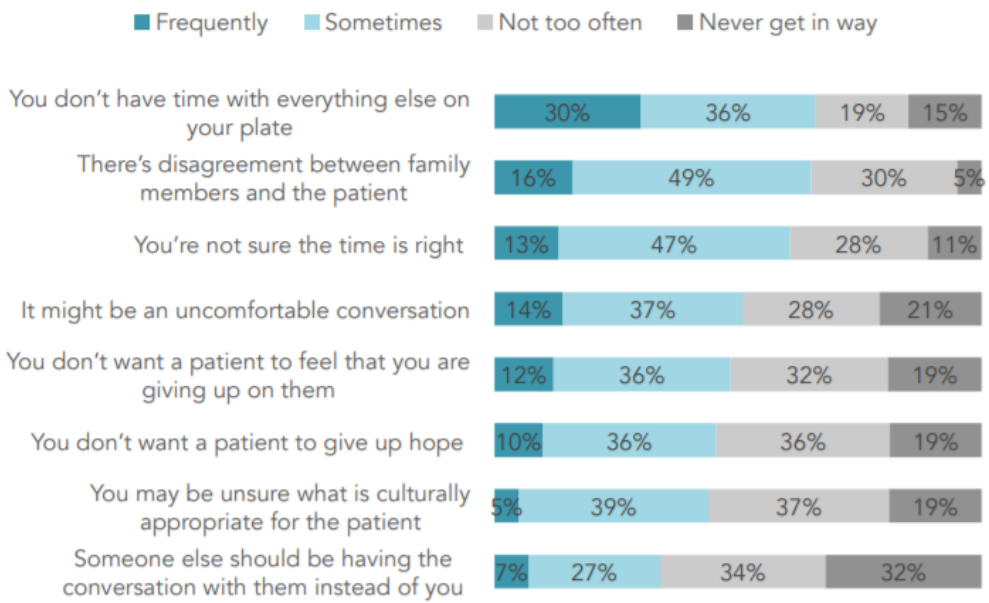
"The Irish believe death is inevitable, the English that death is imminent, the Americans that death is optional"

Whose job is it?

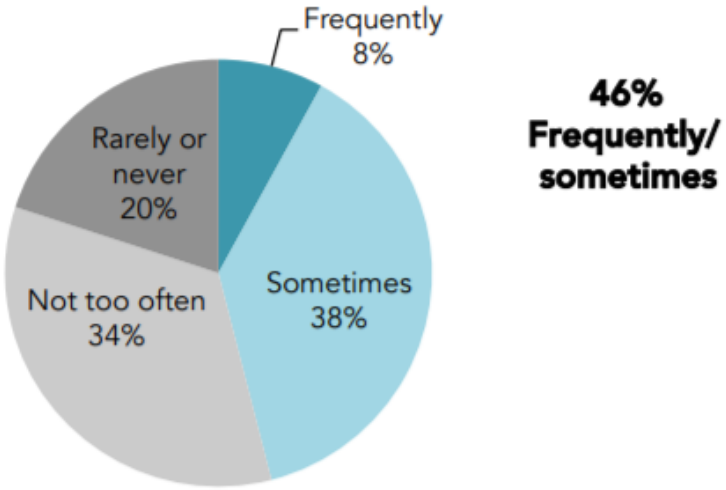
Physicians report a number of barriers in the way of talking to their patients over age 65 about end-of-life wishes. Two-thirds say that time has been a barrier to having these conversations. Other top barriers include disagreements between family members and the patient, not knowing when is the right time to have the conversation, feeling like the conversation might be uncomfortable, not wanting to give up hope, and feeling unsure what is culturally appropriate for the patient.

Think about your patients 65 and older with a serious illness. Have any of the following ever gotten in the way of talking to them about their end-of-life wishes? IF YES: how often does this get in the way for you….

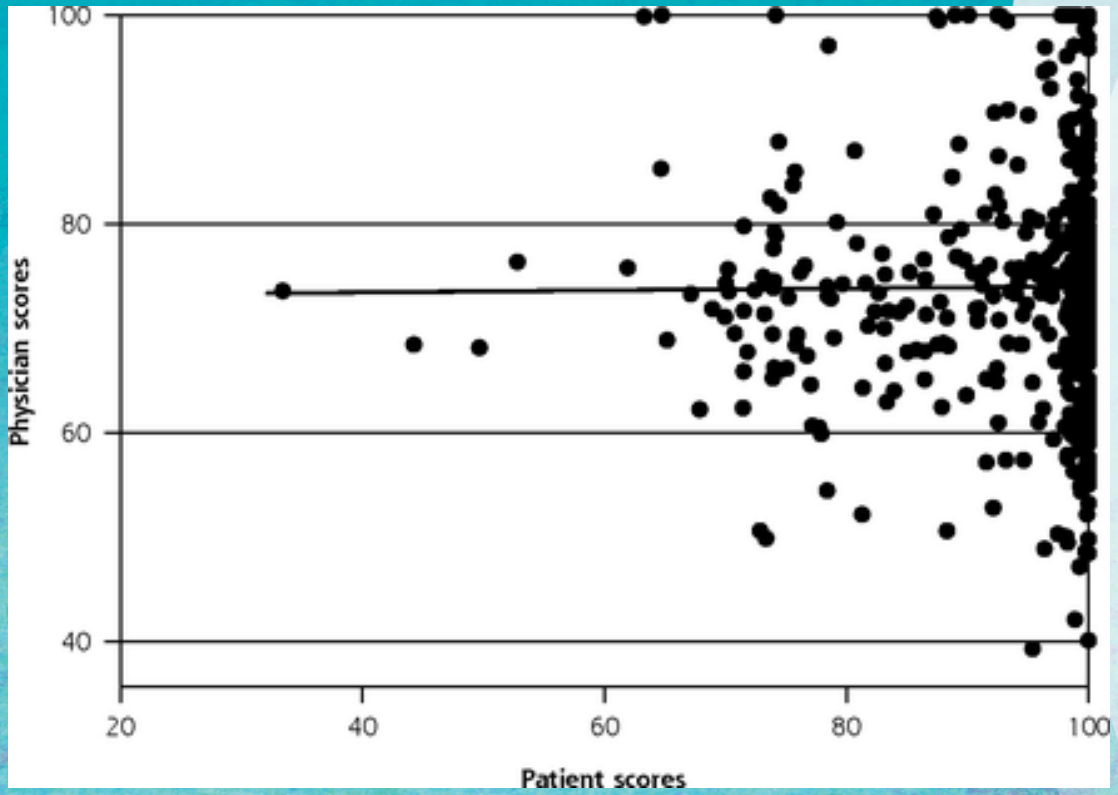


Close to half of physicians surveyed (46 percent) says they frequently or sometimes feel unsure of what to say during conversations about end-of-life care. One-third (34 percent) says they feel this way "not too often." Twenty-percent say they rarely or never feel unsure of what to say.

During conversations about end-of-life care, how often do you feel unsure of what to say? Would you say:



The Evaluation of Physicians' Communication Skills From Multiple Perspectives



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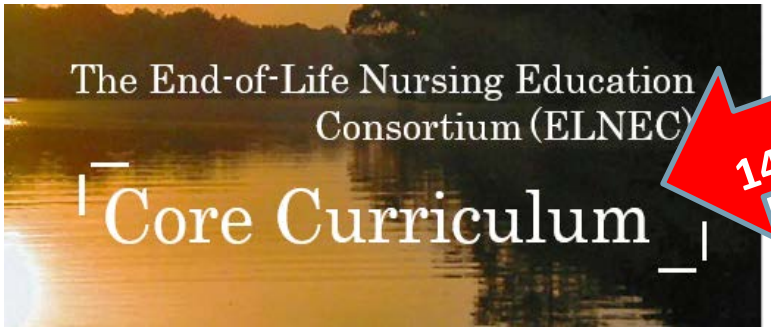
Trainings For MD's/Providers…

In-person, turn-key products for MD's/Providers are all very good (Vital Talk, Respecting Choices, SICP), but…

- Expensive
- Require broad system buy-in/investment/support
- Long-term dedication (creating opportunities to use/teach skills, ongoing mentoring/coaching for skill refinement over the long haul)
- Who do you train? (early adopters; moveable middle; axe carrying resisters..?)
- Is training sufficient for integration? No!

System trainings/resources



Learn Center for Dates & Details

EASTERN AHEC
Area Health Education Center

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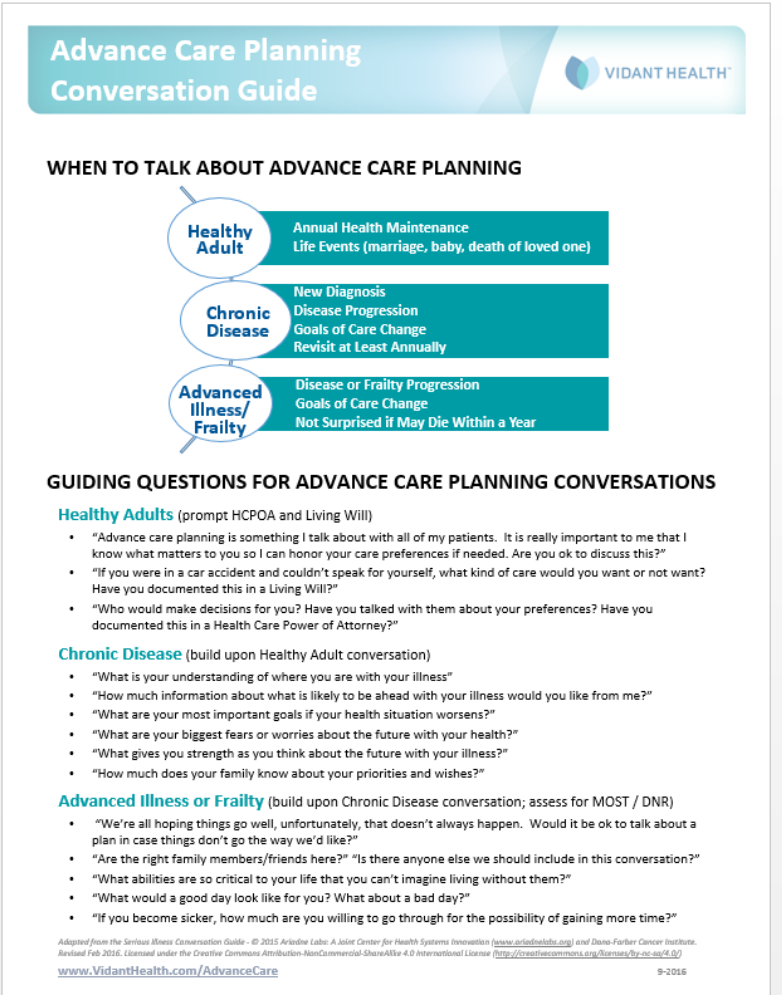

Advance Care Planning Conversation Guide

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WHEN TO TALK ABOUT ADVANCE CARE PLANNING

Healthy Adult	Annual Health Maintenance Life Events (marriage, baby, death of loved one)
Chronic Disease	New Diagnosis Disease Progression Goals of Care Change Revisit at Least Annually
Advanced Illness/ Frailty	Disease or Frailty Progression Goals of Care Change Not Surprised if May Die Within a Year

GUIDING QUESTIONS FOR ADVANCE CARE PLANNING CONVERSATIONS

Healthy Adults (prompt HCPOA and Living Will)

- "Advance care planning is something I talk about with all of my patients. It is really important to me that I know what matters to you so I can honor your care preferences if needed. Are you ok to discuss this?"
- "If you were in a car accident and couldn't speak for yourself, what kind of care would you want or not want? Have you documented this in a Living Will?"
- "Who would make decisions for you? Have you talked with them about your preferences? Have you documented this in a Health Care Power of Attorney?"

Chronic Disease (build upon Healthy Adult conversation)

- "What is your understanding of where you are with your illness"
- "How much information about what is likely to be ahead with your illness would you like from me?"
- "What are your most important goals if your health situation worsens?"
- "What are your biggest fears or worries about the future with your health?"
- "What gives you strength as you think about the future with your illness?"
- "How much does your family know about your priorities and wishes?"

Advanced Illness or Frailty (build upon Chronic Disease conversation; assess for MOST / DNR)

- "We're all hoping things go well, unfortunately, that doesn't always happen. Would it be ok to talk about a plan in case things don't go the way we'd like?"
- "Are the right family members/friends here?" "Is there anyone else we should include in this conversation?"
- "What abilities are so critical to your life that you can't imagine living without them?"
- "What would a good day look like for you? What about a bad day?"
- "If you become sicker, how much are you willing to go through for the possibility of gaining more time?"

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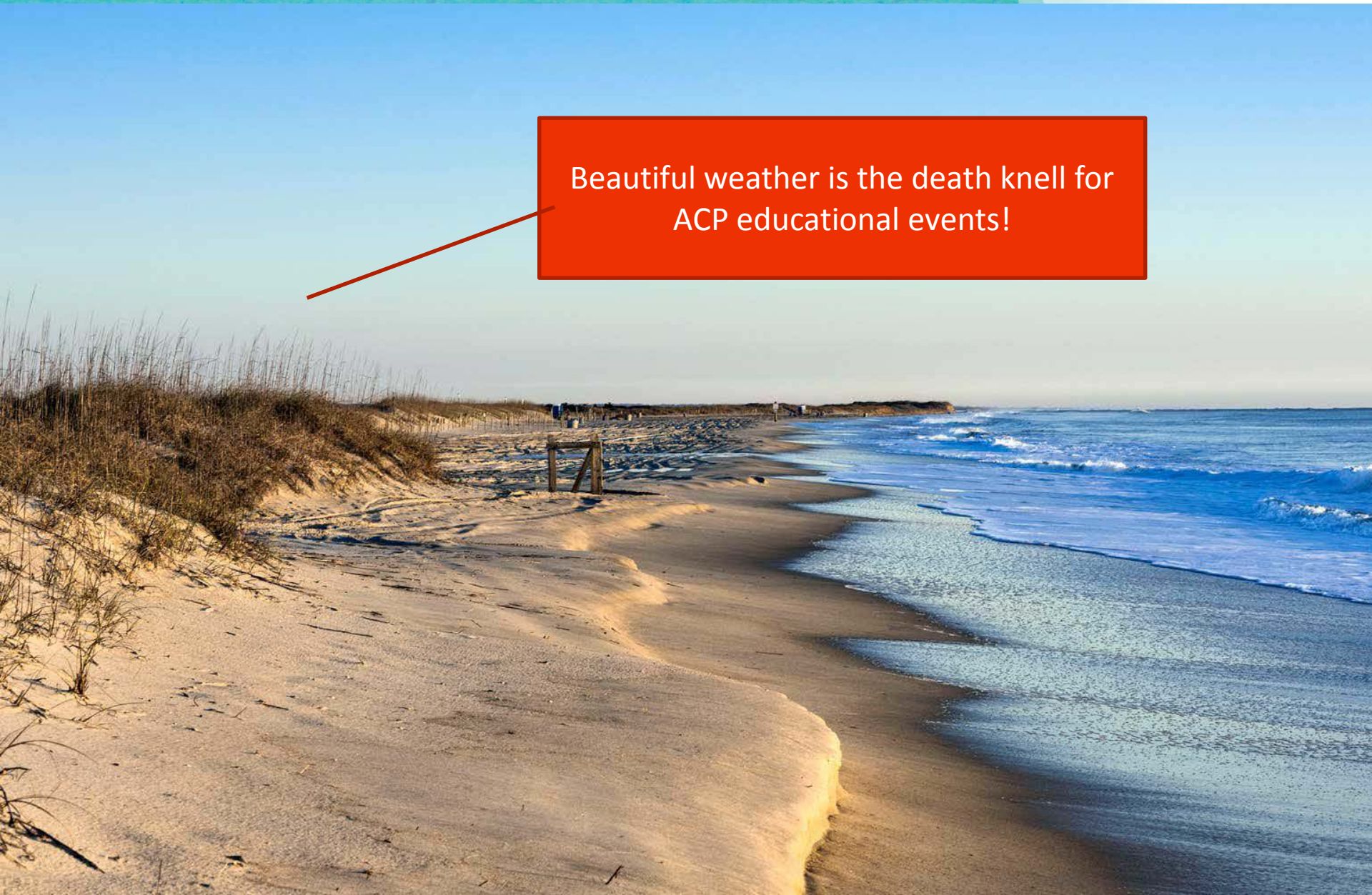
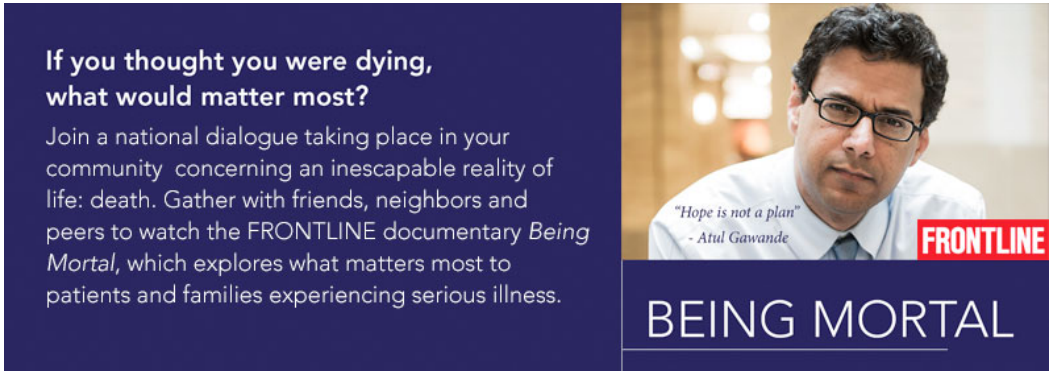
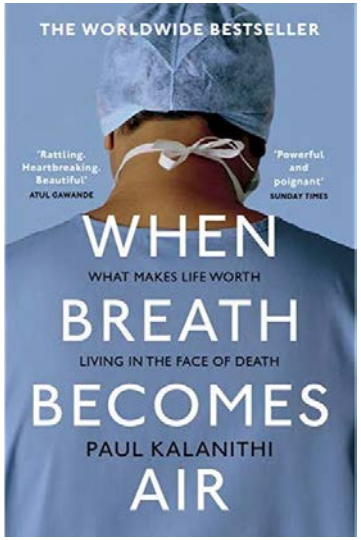
Nurses and other staff

Community members

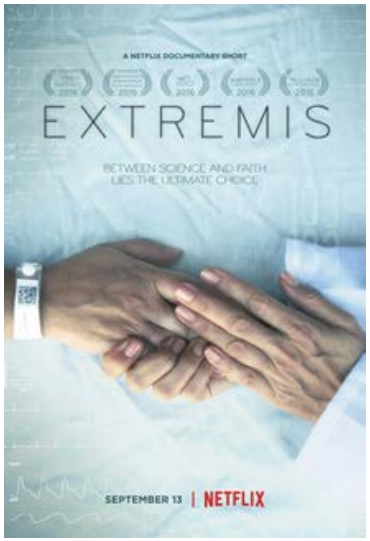


Keeping it fresh…





- NHDD
- Dying to Know: Bringing Death to Life
- Conversation Sabbath



Writing Your Own Obituary- Class at Chowan University

Challenges around ACP communication with patients and families

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You may not control life's circumstances, but getting to be the author of your life means getting to control what you do with them.

-A. Gawande

Requires deep listening

Thank You

"Sometimes we can offer a cure, sometimes only a salve, sometimes not even that. But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the larger aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it the good we do can be breathtaking."

Atul Guwande