Implementation of Advance Care Planning (ACP) Program at Hawaiʻi Pacific Health

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11/19/2015
Hawaiʻi Pacific Health

Kapiʻolani Medical Center for Women & Children

Pali Momi Medical Center

Straub Clinic & Hospital

Wilcox Memorial Hospital
Hawai‘i Pacific Health

Mission: To provide the highest level of care for all of Hawai‘i, every patient, every time

- 4 hospitals
  - Kapi‘olani Medical Center for Women & Children
  - Pali Momi Medical Center
  - Straub Clinic & Hospital
  - Wilcox Memorial Hospital
- More than 50 outpatient clinics and service sites
- 6485 employees
- 1860 physicians on medical staff
- 869 volunteers
- 566 beds
- 34,268 admissions
- 25,918 surgery cases
- 164,482 ER visits
Objectives

1. Discuss the implementation of advance care planning for hospital system and community.

2. Identify ways to standardize and measure ACP documentation in the Electronic Medical Record.
Background

- 7 out of 10 Americans die from chronic disease - congestive heart failure; chronic lung disease, cancer, coronary artery disease, renal failure, peripheral vascular disease, diabetes, chronic liver disease and dementia

- 32% of total Medicare spending devoted to patients with chronic illness in their last 2 years of life
Hospital as Place of Death

State of Hawaii
32.6%

Top 5 States
18.3%
Advance Care Planning

• Advance Care Planning (ACP) is an ongoing process of person-centered communication that includes:
  - understanding
  - reflection
  - discussion
  - documentation about future health care decisions.
Advance Care Planning

- Process of ACP and goals must be defined and standardized.
- ACP conversations are not a one time discussion.
- ACP is best accomplished in stages.
- ACP results in the creation of individualized plans that are understood, accessible and honored.
Stages of Advance Care Planning Over the Lifetime of Adults

**First Steps®**
Create POAHC and consider when a serious neurological injury would change goals of treatment

**Next Steps**
Determine what goals of treatment should be followed if complications result in “bad” outcomes

**Last Steps® or “Last Stages”**
Establish a specific plan of care expressed in medical orders using the POLST paradigm

- **Healthy adults who have not planned**
- **Adults with progressive, life-limiting illness, suffering frequent complications**
- **Adults whom it would not be a surprise if they died in the next 12 months**
Respecting Choices
Last Steps - POLST Paradigm

- To provide a mechanism to communicate seriously ill patients’ preferences for end-of-life treatment across care settings.

- To improve implementation of advance care planning by providing more specific instructions for seriously ill patients.
Key Elements in Designing an Effective ACP Program

#1 System Redesign
- ACP documents
- ACP storage & retrieval
- ACP team & referral

#2 ACP Education and Facilitator Training
- ACP team education
- Other stakeholders

#3 Community Engagement
- ACP education
- ACP materials
- ACP tools

#4 Continuous Quality Improvement
- ACP monthly reports
- Patient wishes followed
#1 System Design: ACP documents

- Identify types of ACP documents
  - AHCD and POLST

- HPH ACP documents include:
  - Advance Health Care Directives and/or Living Will
  - Health Care Power of Attorney (HCPOA) or DPOA (Durable POA)
  - Guardianship
  - Surrogate
  - Provider Orders for Life-Sustaining Treatment (POLST)
#1 System Design: ACP storage

- Health Information Management (HIM) or Medical Record

ACP documents completed
(Legal signatures present as required)

Staff makes a copy of the ACP documents on white paper.
- Original document stays with patient.
- Copy stays in the chart and faxed down to HIM
- ONLY HIM are allowed to scan the ACP documents.

If ACP documents are revised and EPIC has an older version, identify on ACP fax template that copy is an updated version.

HIM will watermark “VOID” on the older version of the ACP documents only when notified. Watermark VOID documents are kept in EPIC and the copy without the watermark will be deleted. The older version of the ACP documents will be found under media tab. Only the current copy will be viewable under ACP documents.

Staff faxes document to HIM fax number using specific fax template
- Kapiolani: 983-8617
- Pali Momi: 485-4372
- Straub: 522-4282
- Wilcox: 245-1038

HIM scans document within 24 hrs. Scanned date will be the at the patient level and effective date will be recorded as well as name of physician or APRN

Note: The copy that is viewable in EPIC is by the most recent scanned date. If the document is void, make sure the newer ACP document is scanned after the voided document. If there is no new ACP document, then the voided document will appear.
#1 System Design: ACP Storage & Retrieval

- Access, visible, easy to find
- Front of patient’s chart
- Specific dedicated area
#1 System Design: ACP team & referral

- Who can facilitate ACP in your organization?
- Roles and responsibilities of the ACP team
- Work flows when an ACP referral is initiated.
- Other resources?
#1 System Design: ACP team & referral

HPH Advance Care Planning order set
#2 ACP Education and Facilitator Certification

- Champion ACP educators
- Creating a culture of ACP awareness:
  - new employee orientation
  - staff meetings
  - huddles
  - CMEs
  - academies
  - skills fairs
  - leadership driven
- ACP Facilitator Certification – Respecting Choices
  - Online modules and classroom training
#2 ACP Facilitator Certification

Total Number of Advance Care Planning Facilitators
2011-2015 YTD (N = 401)
HPH Total = 256

- Harbor Court: 4
- WMH: 39
- PMMC: 47
- SCH: 86
- KMCWC: 80
- Non HPH: 145
#3 Community Engagement

ACP Community Education
- ACP workshops
- Senior fairs
- HPH community conferences
- Long term care collaboration

ACP Materials and Tools
- Kokua Mau – Hawaii Hospice and Palliative Care Organization - www.kokuamau.org
- ACP Decisions Videos – www.acpdecisions.org
- The Conversation Project – www.theconversationproject.org
#3 Community Engagement

ACP Materials and Tools

Advance Care Planning

Being hospitalized with a serious illness can be difficult and confusing. You and your family may have questions about your illness and the choices you make.

Advance Care Planning is the process of understanding, discussing and planning for a time when you cannot make your own medical decisions. This typically involves learning about treatment options, thinking about your decisions with your loved ones and your physician, and documenting those wishes before a crisis occurs. Advance Care Planning is also customized to reflect your personal preferences and health needs, as well as meet your social, cultural and religious requirements.

Advance Care planning helps you through all the stages of illness. It is best introduced early in a person’s care and is an on-going process of respecting the choices that one makes for one’s self. A team of skilled facilitators can help you make the decisions that are right for you.
# 4 Continuous Quality Improvement

- Data collection and analysis

- Reviewing implementation workflows

- Goal is to honor ACP health care decisions and ensure that individuals receive care that matches their goals and values.

- Leadership involvement to remove barriers and make system changes.
Adults and Pediatrics POLST
Kapi‘olani Medical Center for Women & Children
POLST Wishes Honored

POLST Wishes Honored within 12 hrs of Arrival for all Patients who Provided or have POLST on File
Last Stages Patient Discharged with ACP documentation

Last Stages Population Criteria include patients:
- with limited resuscitative orders;
- ≥ 80 yrs. and admitted 2 times in the last 6 months;
- ≥ 90 yrs. or discharged to hospice services

2015
- 59% of Last Stages patients had an Advance Directive and POLST at time of death.
- 4.5% of families changed the patient’s designated directives
- 0.7% of patients changed their own designated directives
State of Hawaii 2007 - 2014
Percentage of All Deaths occurring in a Hospital

Source: Hawaii Health Information Corporation (HHIC) HHIC.org as 4/14/2015 & http://health.hawaii.gov/vitalstatistics/ as 4/15/2015
Mahalo!

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