Topics

1. What is Advance Care Planning (ACP)?
2. Advance Care Planning Project
3. What are the next steps after a notification?
4. How to Document ACP Conversations
5. How to find ACP documents (ACP Banner and Tab)
6. Tips for ACP conversations (including videos)
7. Appendix: Mortality Prediction Model by DIHI

What is Advance Care Planning?

*"Advance care planning (ACP) is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care" **

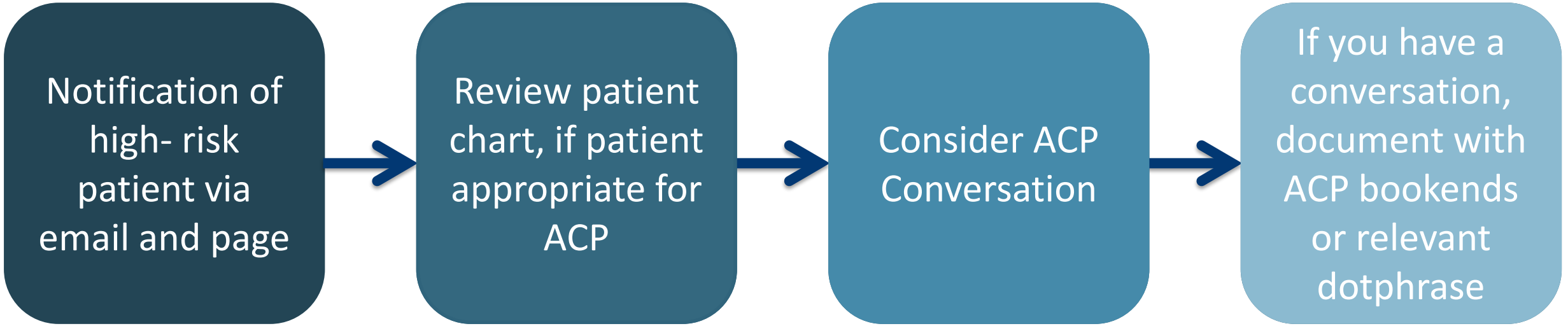
- The goal of ACP is to help ensure that people receive medical care that is consistent with their values, goals, and preferences
- Resuscitation preferences are only part of the conversation

*Sudore RL, Lum HD, You JJ, et al. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. *J Pain Symptom Manage*. 2017;53(5):821–832.e1

Advance Care Planning (ACP) Project

- **Purpose**:
  - Utilize a machine-learning model to identify high-risk patients for Advance Care Planning
- **Who is notified:**
  - Treatment Team
  - Case Management
  - Pharmacy clinical staff
  - Coding Documentation Integrity (CDI) team

What are the next steps after a notification?

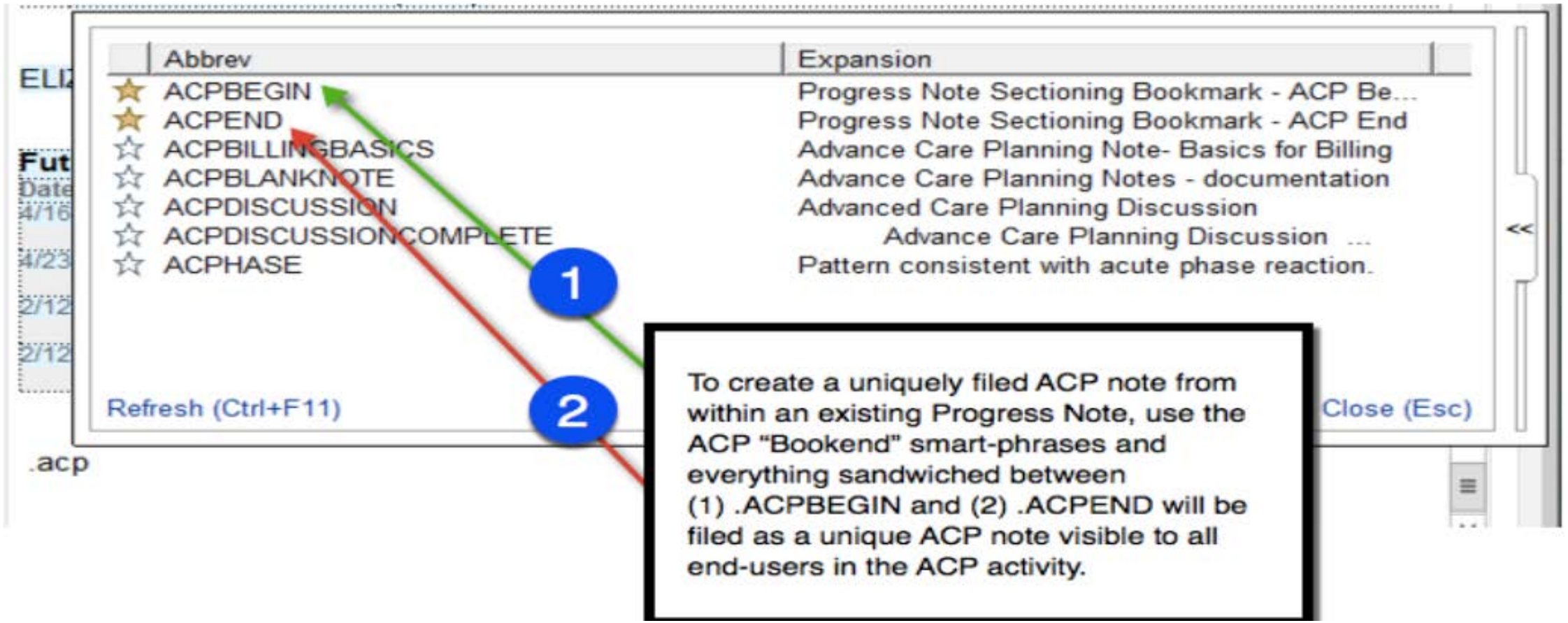


How to Document ACP Conversations

- Use **ACP bookends** or **dotphrase**
  - **.acpbegin and .acpend** bookends store the conversation's documentation in the ACP banner on EPIC
  - **dotphrase** (with built in bookends in template)
    - Hospital Medicine: .gmacp dotphrase
  - Avoid documenting ACP conversations in attending attestations because the note cannot be captured in Epic or stored in the ACP banner
  - Allows note to be visible in ACP banner for future providers in the same or different encounters

ACP Bookends: Embed ACP in any Note

If not using .gmacp dotphrase consider use of bookends to store conversation in ACP tab

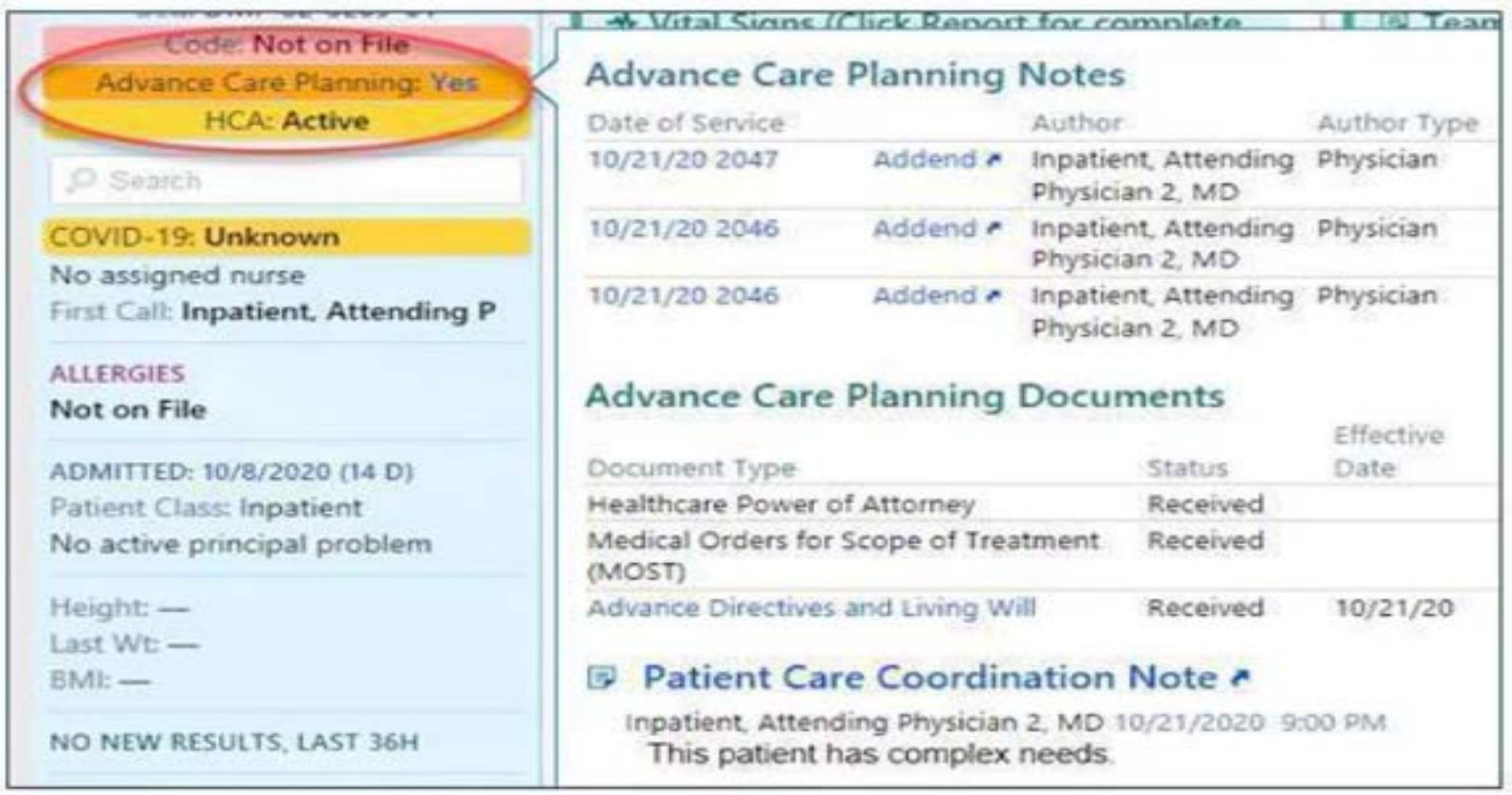


*** Bookends can be used to document ACP conversations in any note type: H&Ps, daily progress notes, or discharge summaries.

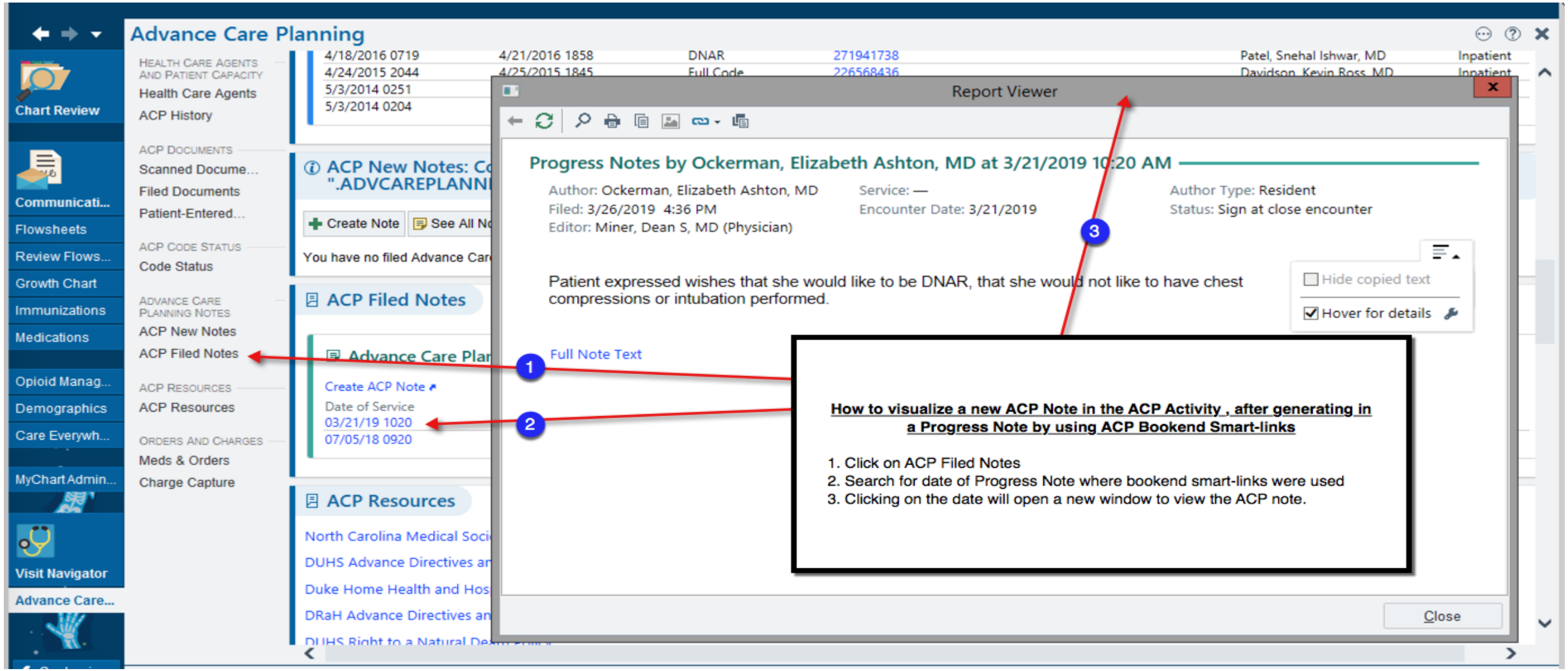
Advance Care Planning (ACP) Banner

- Hover report
- Banner flips to 'Yes' with any ACP Notes/ Documents

Maestro Care Advance Care Planning Banner



Advance Care Planning Banner or Tab



ACP Conversation Tips: REMAP

REMAP	ADDRESSING GOALS OF CARE
REFRAME why the status quo isn't working	*(You may need to discuss serious news such as a scan first.)* *"Given this news, it seems like a good time to talk about what to do now. We're in a different place."*
EXPECT emotion - respond with empathy	*"It's hard to deal with all this."* *"I can see you are really concerned about [x]."* *"Tell me more about that—what are you worried about?"* *"Is it ok for us to talk about what this means?"*
MAP out what's important	*"Given this situation, what's most important for you?"* *"When you think about the future, are there things you want to do?"* *"As you look toward the future, what concerns you?"*
ALIGN with the patient's values	*"As I listen to you, it sounds the most important things are [x-y-z]."*
PLAN to match values	*"Here's what I can do now that will help you do those important things."* *"What do you think about it?"*

Goals of Care Conversations training was developed by VA National Center for Ethics in Health Care through contracts with VitalTalk. Updated 01/2018.
www.ethics.va.gov/goalsofcaretraining/practitioner.asp

ACP Conversation Tips: SPIKES

SPIKES	Delivering Serious News
SETTING	*Find a quiet location; private if possible.* *Invite the important people to be present.* *Have tissues and enough chairs.* *Turn off the ringer on your phone/pager.*
PERCEPTION Determine what the patient knows already	*"Tell me what you understand about your illness."* *"What have the other doctors told you about your illness?"* *Look for knowledge and emotional information as the patient responds*
INVITATION Clarify information preferences	*"Would it be okay for me to discuss the results of your tests with you now?"* *"How do you prefer to discuss medical information in your family?"* *"Some people prefer a global picture of what is happening and others like all the details, what do you prefer?"*
KNOWLEDGE Give the information	*Give a warning..."I have something serious we need to discuss"* *Avoid medical jargon.Say it simply and stop. (e.g."Your cancer has spread to your liver. It is getting worse despite our treatments.")*
EMPATHY Respond to emotion	*Wait quietly for the patient.* *"I know this is not what you expected to hear today.""This is very difficult news."*
SUMMARY Next steps and followup plan	*"We've talked about a lot of things today, can you please tell me what you understand."* *"Let's set up a follow-up appointment."*

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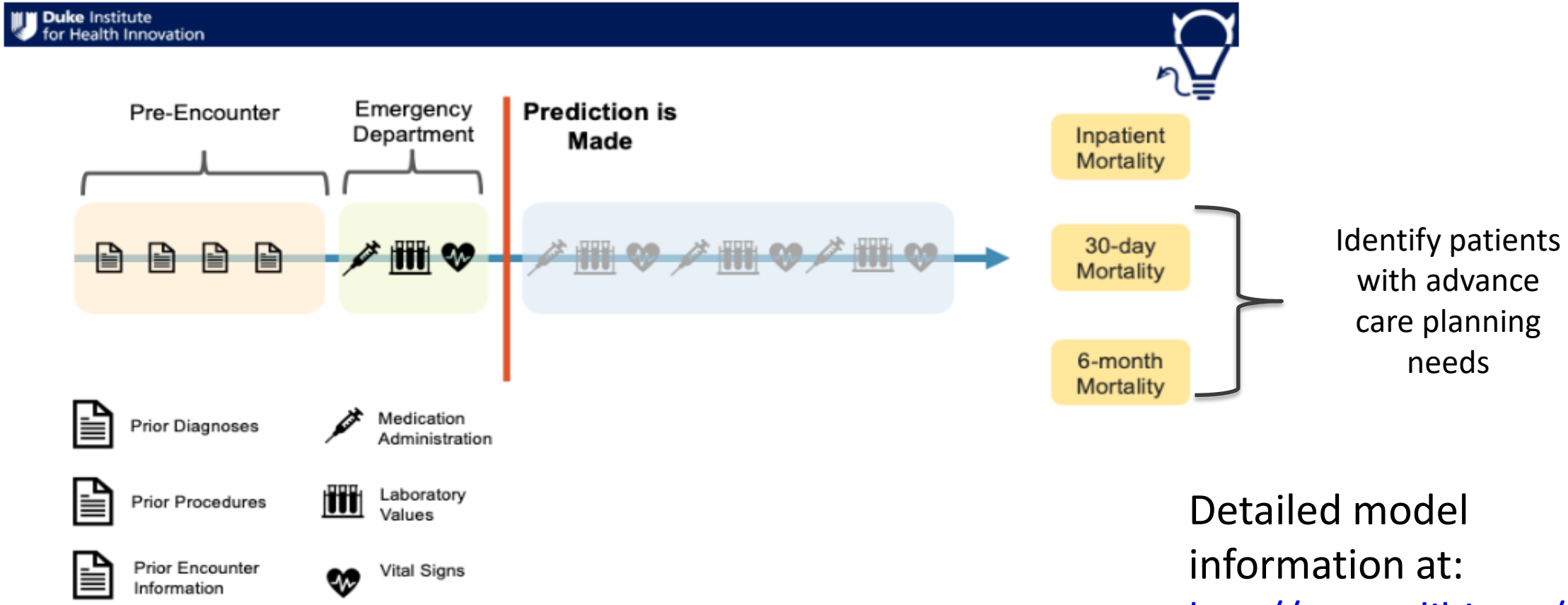
Duke CARES (Conversations Anchored in Respect, Evidence, and Shared decision-making)

- Videos on ACP
  - Topics include:
    - Documenting in Epic
    - Family Meeting Pearls
    - Miracles
    - Prognostication
    - Sharing Serious News
    - When Surrogates Disagree
    - Hospice Myths

- https://sites.duke.edu/dukepalliativecaretaskforce/

Appendix: Mortality Prediction Model



The mortality models use the information described in order to predict a patient's risk of dying within the hospital stay (inpatient mortality), within 30 days of admission, or within 6 months of admission.

Detailed model information at: http//www.dihi.org/mortality_evaluation