

**Respecting Choices®**  
PERSON-CENTERED CARE

**ACP Facilitator Certification**  
**ACP Core Component Course**

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**Honoring Choices PNW Instructors**



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**Course Participants**

Introduction:

- Name
- Title
- Organization
- One skill you would like to learn during this course

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# ACP Facilitator Certification ACP Core Component PowerPoint Handout

**HCPNW Vision**

**Vision:** Everyone will receive care that honors personal values and goals at the end-of-life.

An initiative to inspire conversations about the care people want at the end-of-life.

- **Public:** Make informed choices about end-of-life care.
- **Health systems, hospitals, and medical groups:** Discuss, record and honor end-of-life choices.



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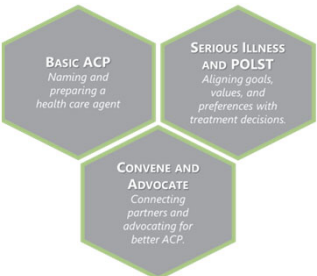
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**2022 Strategic Focus**



- BASIC ACP**  
*Naming and preparing a health care agent*
- SERIOUS ILLNESS AND POLST**  
*Aligning goals, values, and preferences with treatment decisions.*
- CONVENE AND ADVOCATE**  
*Connecting partners and advocating for better ACP.*



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**Respecting Choices Certification**

Respecting Choices® offers certification for Facilitators and Instructors associated with specified skills-based educational programs for ACP and SDMSI, which includes:

1. The use of standardized curricula, conversation guides, and materials;
2. Competency validation through demonstrated acquisition of knowledge and skills;
3. Completion of initial certification requirements; and
4. Ongoing maintenance of competency and/or recertification (as applicable).



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**Learning Outcomes**

1. Identify intended populations for advance care planning conversations.
2. Verbalize strategies to engage individuals and healthcare agents in advance care planning.
3. Demonstrate communication skills to promote person-centered conversations.
4. Apply critical thinking to discern what matters most to individuals.

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**Insights from Precourse Activities**

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**Person-Centered  
Conversations:  
Core Concepts**

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**Knowing and Honoring Preferences and Decisions**

“ Care that is respectful of and responsive to individual patient preferences, needs, and values, ensuring that patient values guide all clinical decisions ”

ICM Report 2001. Crossing the Quality Chasm: A new health system for the 21st Century. Washington, D.C. National Academy Press.

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**Person-Centered and Family-Oriented Care**

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**Advance Care Planning (ACP)**

ACP is a process of communication for planning for future medical decisions. To be effective, this process includes:

- **Reflection** on goals, values, and beliefs (including cultural and/or spiritual beliefs)
- **Understanding** of possible future situations and decisions
- **Discussion** of these reflections and decisions with others, including those who might need to carry out the plan

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# ACP Facilitator Certification ACP Core Component PowerPoint Handout

## Shared Decision Making

SDM is a process in which clinicians and patients work together to make decisions that align with what matters most to patients.

*"...shared decision making respects autonomy and builds relationships based on respect for and curiosity about the patient as a person...relies on fundamental communication skills—developing trust, understanding, empathy, and patient enablement to facilitate decision making."*

Ehryn, G. et al. (2014). Shared decision making and motivational interviewing: achieving patient-centered care across the spectrum of health care problems. *Annals of Family Med*, 12(3), 270-275. <https://doi.org/10.1370/afm.1615>

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## The Five Promises

				
PROMISE 1	PROMISE 2	PROMISE 3	PROMISE 4	PROMISE 5
We will initiate conversations.	We will provide assistance with person-centered decision making.	We will make sure plans are clear.	We will store, update, and use plans.	We will honor preferences and decisions.

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## Stages of Person-Centered Decision Making

ONGOING ADVANCE CARE PLANNING			Certified Facilitator
<b>FIRST STEPS® ACP</b> <u>Target Population:</u> Individuals who are healthy or have early chronic illness	<b>NEXT STEPS™ ACP</b> <u>Target Population:</u> Individuals with serious illness who have potential for complications	<b>ADVANCED STEPS ACP</b> <u>Target Population:</u> Individuals who are in their last few years of life	
<b>SHARED DECISION MAKING IN SERIOUS ILLNESS™</b> <u>Target Population:</u> Individuals with serious illness making current healthcare decisions			Physician

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**Desired Outcome of Person-Centered Decision Making**

The desired outcome of person-centered decision making (PCDM) is to **know and honor** individuals' well-informed preferences and decisions by...

- **Creating an effective process** to plan for current and future decisions
- **Making plans available** to treating health professionals
- **Assuring plans are incorporated** into current medical decisions

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**First Steps ACP**

**Intended Population**

- Healthy Individuals
- Adults with early chronic illness
- Any adult as part of ongoing ACP activities

**Outcomes of First Steps ACP Conversation**

- Proactive planning for future health care decisions
- Selection and preparation of healthcare agent(s)
- Goals of care for a sudden illness or injury
- ACP documentation and advance directive documents

**Sites of Care**

- Outpatient/Inpatient/Post-acute care settings
- Varied community settings

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**ACP Team Education**

Standardized education allows delivery of a consistent and reliable ACP service across care settings.



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**Advance Care Planning Introduction Guide**  
**(RC 0036)**

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*How do you see this role supporting person-centered decision making?*

**ACP Facilitator Role and Responsibilities**

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**Role of the ACP Facilitator**

- Motivate individuals to participate in proactive planning
- Guide ACP conversations
- Identify needs of individuals and healthcare agents
- Create follow-up plans and referrals
- Create, review, and/or update ACP documents
- Support ACP program

➔ Refer to RC 0087

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**Flexibility within a Framework**

- Essential for person-centered conversations and shared decision making
- Requires critical thinking skills



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**A Person-Centered Approach**

- Promote flexibility within the framework.
- Begin with exploring what matters most to individuals.
- Allow individual and agent to **tell their stories**.
- Promote deeper *reflection, understanding, and discussion*.



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**Skills To Promote Person-Centered Conversations**

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**Self-Reflection**



What do we need to do differently?

↓

What habits, biases, and behaviors do we need to unlearn?

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What communication skills do we need to develop?

Refer to RC 0003

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**Communication Skills**

- **Explore meaning of words/phrases**  
*"What does 'I feel like a burden' mean to you?"*
- **Paraphrase/clarify**  
*"You were frustrated being in the hospital; tell me more."*
- **Ask, "Anything else?"**  
*"You have said you are weak, tired, and frustrated. Anything else?"*
- **Listen for and summarize themes**  
*"You have talked about how difficult it was making decisions when your father was seriously ill. This conversation can help better prepare your family."*
- **Affirm/reaffirm purpose of conversation**  
*"You say this conversation is hard for you. I hope to help you today, to make it easier to learn how to talk to each other."*
- **Verbalize empathy**  
*"I'm sorry to hear you lost your job. I see that this is very upsetting."*

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**Additional Communication Techniques**

- **Use the Ask-Teach-Ask technique**  
When providing information:
  1. First, ASK...what the individual understands.
  2. Then, TEACH...provide information to fill in gaps in understanding.
  3. Last, ASK (i.e., Teach-Back)...assess understanding of information before moving on.*"These are new ideas for many people, so I want to make sure I was clear. Can you tell me what you now understand about \_\_\_\_\_?"*
- **Remain value-neutral**  
Avoid words, phrases, or nonverbal expressions that may communicate personal biases or values.
- **Pay attention to nonverbal communication**  
(facial expressions, body movements)

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**Critical Thinking Skills**



- Think about your thinking.
- Be curious and open to learning.
- Actively listen and identify when to ask more thought-provoking exploratory questions.
- Encourage self-discovery and team approach to problem-solving.
- Adapt within each phase of conversation to meet the needs of each individual.

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**ACP Conversation Framework**



Exploration      Goals of Care & Decision Making      Summary

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**Prepare for the Conversation**

- Learn about the individual.
  - Review pertinent medical history, any previous ACP, and additional information.
  - Talk to person’s doctor(s) or other care team members, if appropriate.
- Determine who should be present for the conversation.
- Schedule conversation (individual/healthcare agent).

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**Exploring what matters most**

## The Exploration Phase of ACP Conversations

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**LEARNING TOOL: EXPLORATION PHASE OF ADVANCE CARE PLANNING (ACP) CONVERSATIONS**

Part A: Exploratory Sections for Conversations With All Individuals

Part B: Additional Exploratory Sections for Individuals With Chronic or Serious Illness

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**Part A: Exploratory Sections for Conversations With All Individuals**

## Learning Tool – Part A

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**Exploring Understanding of ACP**

- Introduce and explore understanding of ACP.
- Provide information on ACP and/or ACP documents (e.g., AD, POLST), as needed.
- Use Ask-Teach-Ask technique (teach-back method) to assess understanding.

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**Key Messages of ACP Description**

- For adults to think and talk about future healthcare decisions and what matters most
- If unexpected injury/illness occurs and unable to communicate
- Others need to make healthcare decisions for you
- Conversation to prepare your chosen healthcare agent to make decisions that align with your goals, values, and beliefs

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**Explore Existing Advance Directive**

- For individuals who have completed an AD, attempt to explore understanding and opportunity for review by asking:
  - “What do you hope this document will do for you in the future?”
  - “This conversation may help you update your plan.”
  - “Have you chosen a person who would make decisions for you?”
  - **If yes:** “What conversations have you had with this person?”

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**Intent of Exploring Fears and Concerns**

- Why is it important to explore fears and concerns about advance care planning?
  - To address and remove barriers
  - To use a motivational communication technique to promote behavior change
  - To normalize ACP



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**Choosing a Healthcare Agent**

- Why is choosing this person important?
- Why is choosing an alternate agent important?
- Provide written information on the role of the healthcare agent.
- Assess understanding of agent's role.



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**Strategies When No Agent Selected**

- Explore options for choosing a healthcare agent
- Communicate expressed goals and values in writing
- Assure providers/care teams have access to ACP documents/conversation
- Educate individual about storage and retrieval options in community settings



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**Decision-Making Capacity**

The ability to make one's own decisions includes four components:

- 1) the ability to understand that one has authority—that there is a choice to be made,
- 2) the ability to understand information (the elements of informed consent),
- 3) the ability to communicate a decision and associated rationale, and
- 4) the ability to make a decision consistent with one's values and goals that remains consistent over time—or to be able to explain why one's values have changed.

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**Individuals Who Lack Decision-Making Capacity**

**Key themes for Facilitators to consider:**

- Meet with agent or designated decision maker and other family.
- Assist decision makers in reflecting on their loved one's previously stated goals, values, and preferences.
- Base decisions on what individual would have wanted, **not** what decision maker wants.

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 **ACP Conversation with Individual (healthy adult) and Healthcare Agent: Exploration**



*What skills did you observe?*

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**Intent of Exploring Living Well**

- Listen for themes that relate to quality of life (e.g., *“What brings meaning to your life now?”*).
- Explore changes which impact quality of life and may connect to acceptable and unacceptable outcomes.
- Why explore fears and worries as part of living well?
- Summarize goal or value statements that may impact decision making.

Schwartz, 2003

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**Intent of Exploring Experiences**

- Listen for experiences that relate to ACP, with serious illness decision making.
- Listen for experiences that relate to life-sustaining treatment decisions to connect to future planning and goals of care.
- Ask, *“What was learned?”* several times to promote deeper reflection and discussion.

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**Intent of Exploring Beliefs**

- Every individual may have beliefs that might impact care and treatment choices.
- Be aware of own assumptions or biases to remain value neutral.
- Bring forward what was expressed up to this point related to beliefs, cultural traditions, and spiritual practices.
- Encourage introspection of what’s most important for their care team to know.
- Listen for themes and ask more exploratory questions.
- Explore existing supports and/or additional resource needs.

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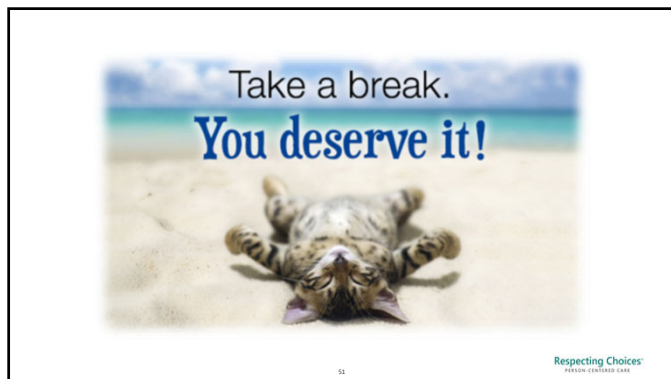
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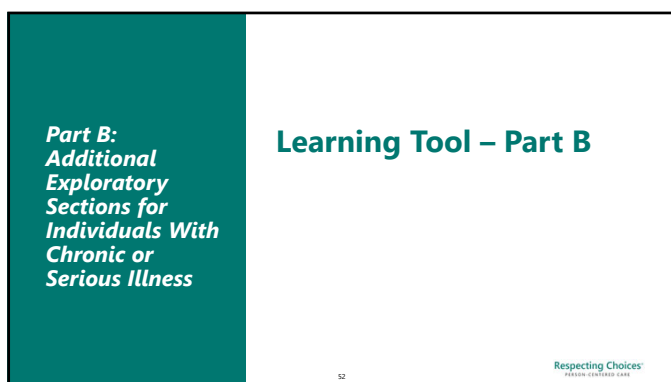
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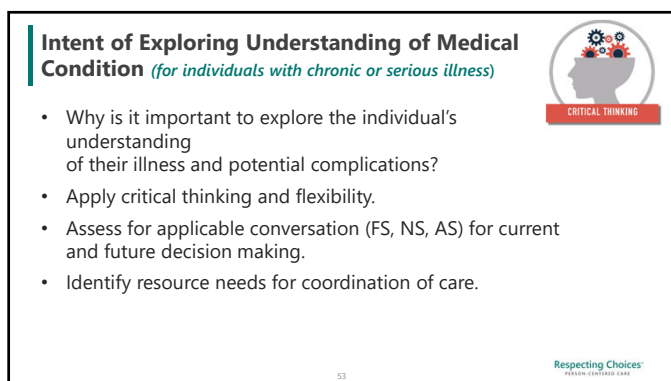
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 **ACP Conversation with Individual (with serious illness) and Healthcare Agent: Exploration**



*What critical thinking skills did you observe?  
What themes did you identify?*

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**Hope: A Powerful Exploration**

- People have “layers” of hope.
- Listen for hopes that may not come true (e.g., “I hope to be as independent for as long as possible,” or “I hope that the providers are wrong about my diagnosis.”).
- People may have conflicting hopes that need to be acknowledged and prioritized.
  - “I never want to go back to the hospital,” *and*
  - “I want to live as long as possible.”
- People may have hopes that you can help them achieve symbolically, if not literally.

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**Intent of Exploring Hopes**  
*(for individuals with chronic or serious illness)*



**CRITICAL THINKING**

- What are fears or concerns when exploring hopes?
- Are there any “wrong” hopes?
- How might the Facilitator use this information?
- What did you learn during this reflection?

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**Explore Hospital Experiences**  
*(for individuals with chronic or serious illness)*

**Facilitator needs to:**

- Understand how exploring lived experiences may frame the individual's goals for medical care.
- Start to identify goals and values important to the individual.
- Assures individual considerations are part of care planning.
- Assess care coordination needs.

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**Closing the Exploration phase**

Purpose: A "transition point" in the conversation

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**Role-Play Exercise:  
Exploration Phase**

Follow the instructions on the  
ROLE-PLAY PACKET.

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**Debrief: What Skills Did You Learn?**

**Common themes**

- Feeling awkward using a conversation guide
- Finding that listening to responses is challenging
- Remembering to use communication skills and critical thinking to deepen the conversation
- Staying on track; redirecting as appropriate
- What else?

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**Additional Conversation Tips**

**Improve confidence and competence**

- Understand the conversation guide framework.
- Apply flexibility within the framework.
- Pace the conversation.
- Use active listening and intentional silence.
- Listen for themes that support goals of care discussions.
- Promote dialogue between the individual and agent.

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