Respecting Choices®
PERSON-CENTERED CARE

ACP Facilitator Certification

First Steps® ACP Intensive Course

RC 1100-I_FSFcltrPPt_12.21 CML

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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: First Steps Certification

1. Define benefits of First Steps conversation and identify appropriate target population.
2. Demonstrate the application of the person-centered decision-making framework to elicit preferences and decisions.
3. Create strategies to transfer individual goals, values, and preferences to a written plan.
4. Demonstrate beginning competency in facilitating First Steps ACP conversations through role-play exercises.

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Insights from ACP Core Component Course and Precourse Activities

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Stages of Person-Centered Decision Making

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Benefits of First Steps ACP

- Intended population for First Steps ACP conversations:
  - Healthy individuals
  - Adults with early chronic illness
- Selecting and preparing healthcare agent(s)
- Discussing goals of care for a severe, permanent brain injury
- Creating a plan (e.g., advance directive)
- Communicating what is learned to the individual's care team(s)

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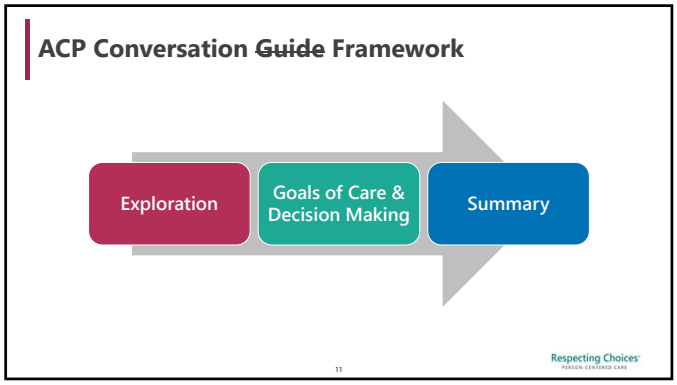

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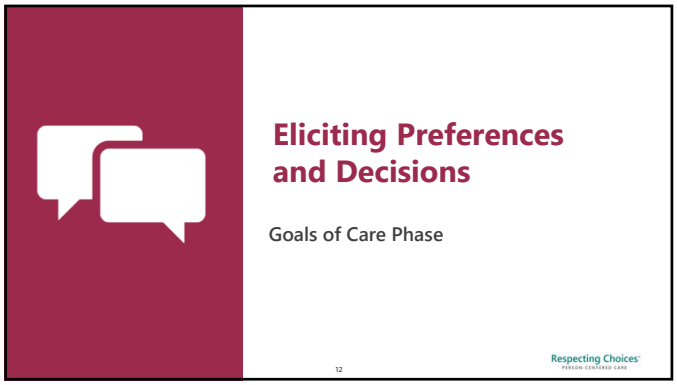

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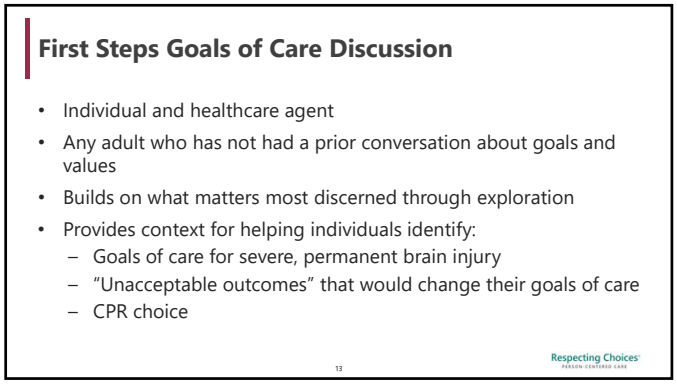

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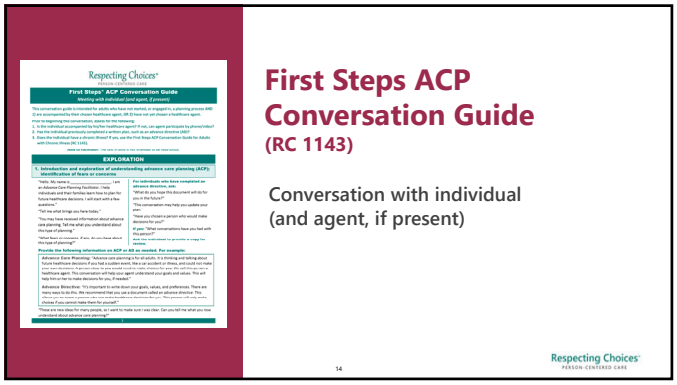

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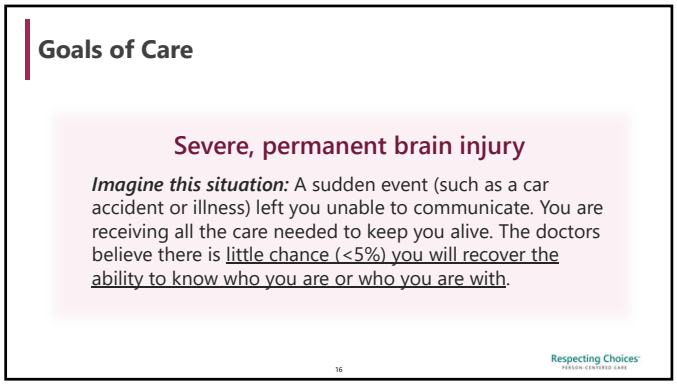

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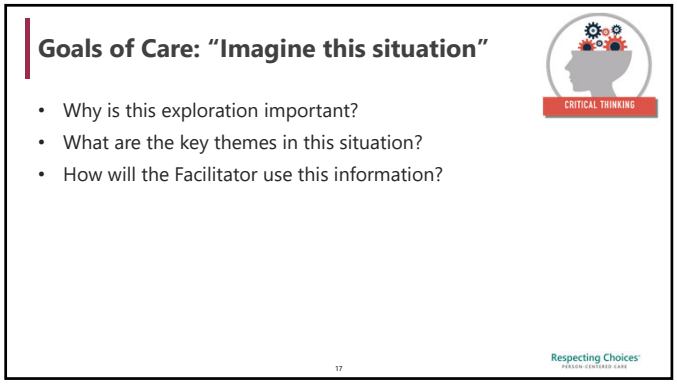

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Define Goals of Care in a Sudden Event

Use Ask-Teach-Ask technique to promote understanding and discussion

- Ask individual to explain the situation in their own words.
- Listen for gaps in understanding.
- Provide clarification.
- Ask individual and agent for questions.
- Explore meaning of words and phrases.

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ACP Conversation with Individual (healthy adult) and Healthcare Agent: Goals of Care

Define goals for severe, permanent brain injury.
How is this approach different from the exploration phase?
Identify the goals of care.

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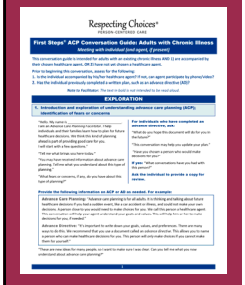
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First Steps® ACP Conversation Guide: Adults with Chronic Illness
Meeting with individual (and agent, if present)
EXPLORATION

First Steps ACP Conversation Guide: Adults with Chronic Illness (RC 1145)

Conversation with individual (and agent, if present)

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Embedding ACP into Chronic Illness Management

- A component of routine care
- Normalizes the conversation
- Uncovers gaps in information
- Empowers individual with skills in making informed healthcare decisions
- Improves communication with providers
- Identifies needs for services and referrals

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ACP for Adults with Chronic Illness: What's Different?

- Explore understanding of medical condition.
- Explore experiences (including past hospitalizations).
- Explore worries, fears, and need for services.

Why is this exploration important in preparation for the Goals of Care discussion?

How will the Facilitator use this information?

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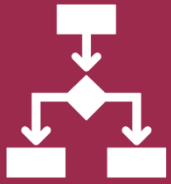

Decision-Making Framework for First Steps ACP Conversations

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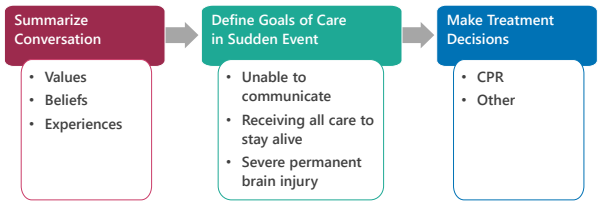
First Steps Goals of Care Pathway



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A Person-Centered Approach to Making Any Treatment Decisions

The Decision-Making Framework

- Explore understanding of treatment decision.
- Explore understanding of benefits and burdens.
- Explore goals for treatment.
- Explore fears and concerns.

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Goals of Care Phase: CPR Decision

Facilitator needs to know:

- How Exploration phase may frame individual's goals for care
- Meaning and intent of treatment options
- Framework for promoting dialogue and understanding between individual and healthcare agent
- Common questions and concerns that arise
- Strategies to promote an informed choice

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The CPR Conversation

How is this approach different using the decision-making framework and CPR Facts sheet?

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Honoring Choices PNW CPR Statistics

- Overall, for all hospitalized adults, there is a **24.8% chance of survival** for in-hospital CPR and live to discharge.
- For adults **18–64 years** old, there is **a 30.4% chance of survival** for in-hospital CPR and live to discharge.
- For adults **older than 64** years, there is an **18.3% chance of survival** for in-hospital CPR and live to discharge.
- For **adults who survive** in-hospital CPR, there is a **28.1% chance of significant neurological disability**.
- For patients **living in a nursing facility and dependent on others** for their care, the odds are **much lower for surviving** in-hospital CPR and discharge alive compared with independent community dwelling members.

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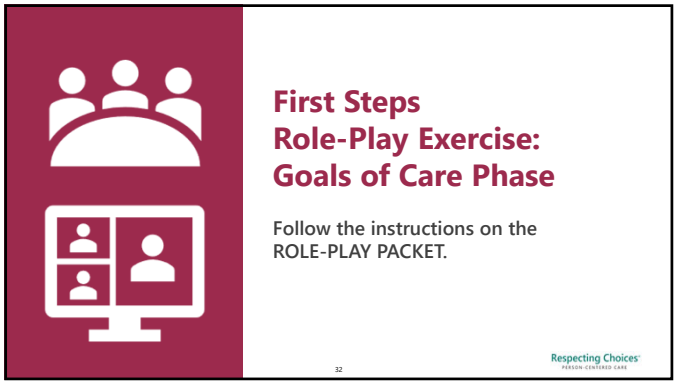

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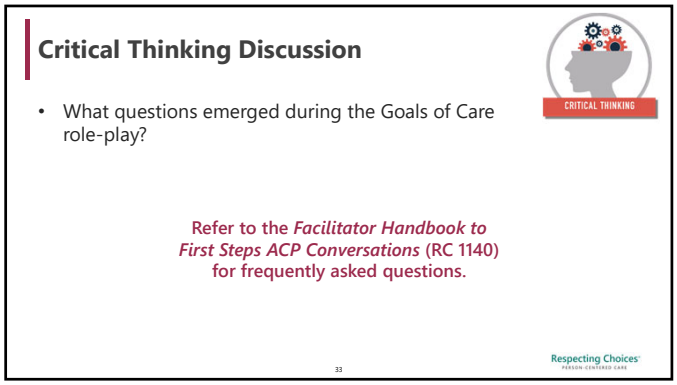

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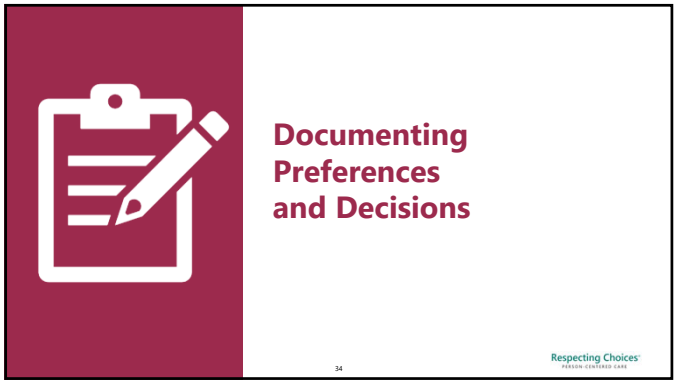

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Common Problems with Written Plans

- Technical errors or gaps
- Ambiguous statements or phrases that are difficult to interpret in the clinical setting (e.g., *"Don't use any tubes to keep me alive."*)
- Lack of specific planning to honor individual's preferences

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Matthew's Goals

- To have a "good" chance of recovering his ability to know who he was, defined as greater than 50% (less than 5% is unacceptable to Matthew)
- To stop medical treatment if there was less than a 50% chance of recovering his ability to know who he was

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Matthew's Advance Directive Statement

"If I am sick or injured and my doctors believe there is less than a 50% chance that I will recover the ability to know who I am, or who I am with, I want to refuse or stop all treatments."

See Facilitator Handbook (RC 1140), Appendix I.

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

What are some of the strategies to honor the plan?

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Summary Phase: Follow-Up Activities

- Create individualized strategies for follow up.
  - If healthcare agent present/not present
- Explain how decisions from conversation transfer to the advance directive document.
  - Validate alignment between decisions and completed form.
  - Complete or update advance directive document.
- If current medical plan of care needs to change based on conversation, communicate with appropriate care team members.
- Make referrals, as needed.
- Document conversation per organization standards.

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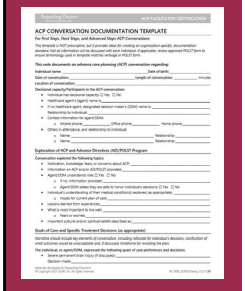

ACP Conversation Documentation Template

(RC 0092)

Create documentation expectations for ACP conversations

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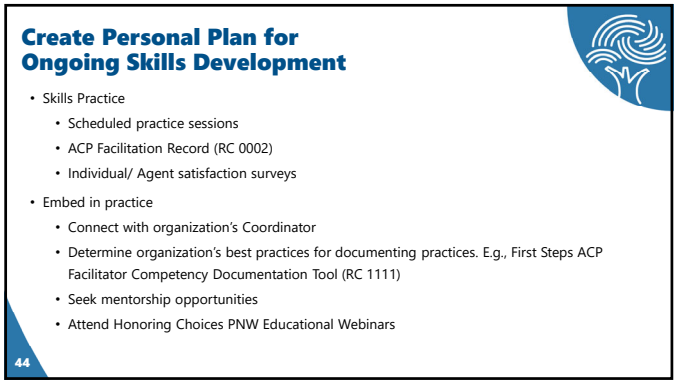

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Share A New Insight From Today

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Thank you!

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