

Respecting Choices®
PERSON-CENTERED CARE

ACP Facilitator Certification
First Steps® ACP Intensive Course

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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

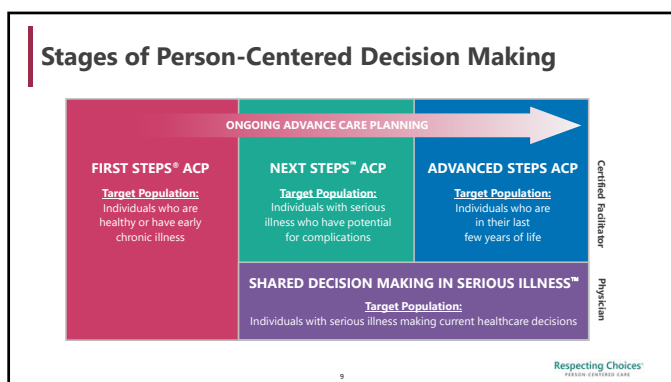
1. Define benefits of First Steps conversation and identify appropriate target population.
2. Demonstrate the application of the person-centered decision-making framework to elicit preferences and decisions.
3. Create strategies to transfer individual goals, values, and preferences to a written plan.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

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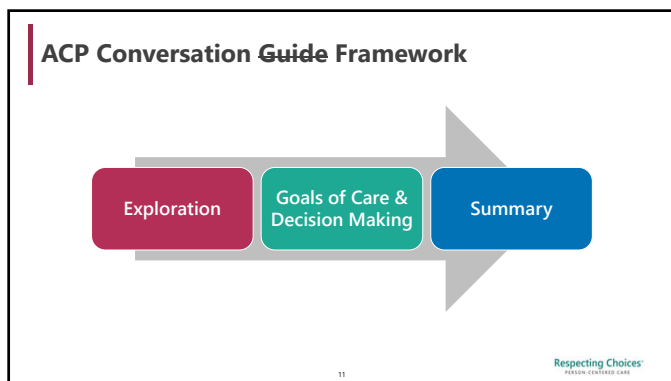
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- Benefits of First Steps ACP
- Intended population for First Steps ACP conversations:
 - Healthy individuals
 - Adults with early chronic illness
 - Selecting and preparing healthcare agent(s)
 - Discussing goals of care for a severe, permanent brain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

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Eliciting Preferences and Decisions

Goals of Care Phase

The slide features a maroon background on the left side with two white speech bubble icons. The text is on a white background. The 'Respecting Choices' logo is in the bottom right corner.

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First Steps Goals of Care Discussion

- Individual and healthcare agent
- Any adult who has not had a prior conversation about goals and values
- Builds on what matters most discerned through exploration
- Provides context for helping individuals identify:
 - Goals of care for severe, permanent brain injury
 - “Unacceptable outcomes” that would change their goals of care
 - CPR choice

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First Steps ACP Conversation Guide (RC 1143)

Conversation with individual (and agent, if present)

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Goals of Care

Severe, permanent brain injury

Imagine this situation: A sudden event (such as a car accident or illness) left you unable to communicate. You are receiving all the care needed to keep you alive. The doctors believe there is little chance (<5%) you will recover the ability to know who you are or who you are with.

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Goals of Care: "Imagine this situation"


- Why is this exploration important?
- What are the key themes in this situation?
- How will the Facilitator use this information?

CRITICAL THINKING

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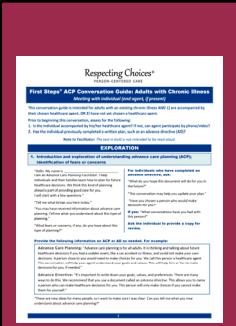
ACP Conversation with Individual (healthy adult) and Healthcare Agent: Goals of Care



*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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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?

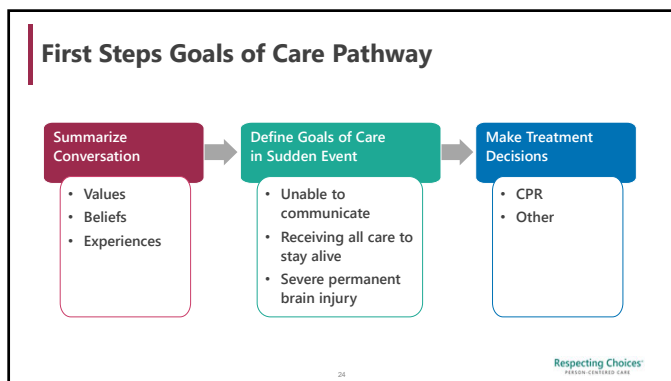
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 **Decision-Making Framework for First Steps ACP Conversations**

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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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Take a break.
You deserve it!



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**First Steps
Role-Play Exercise:
Goals of Care Phase**

Follow the instructions on the
ROLE-PLAY PACKET.

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Critical Thinking Discussion

- What questions emerged during the Goals of Care role-play?

Refer to the *Facilitator Handbook to First Steps ACP Conversations (RC 1140)* for frequently asked questions.




CRITICAL THINKING

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**Documenting
Preferences
and Decisions**

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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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**First Steps ACP
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Competency Role-Play
Review your self-assessment

- What skills came through as strengths?
- What do you need to improve your skills?

What comes next?

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**Competency Role-Play
for First Steps ACP
Facilitator Certification**

Follow the instructions on the
ROLE-PLAY PACKET.

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**Create Personal Plan for
Ongoing Skills Development**

- Skills Practice
 - Scheduled practice sessions
 - ACP Facilitation Record (RC 0002)
 - Individual/ Agent satisfaction surveys
- Embed in practice
 - Connect with organization's Coordinator
 - Determine organization's best practices for documenting practices. E.g., First Steps ACP Facilitator Competency Documentation Tool (RC 1111)
 - Seek mentorship opportunities
 - Attend Honoring Choices PNW Educational Webinars

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Share A New Insight From Today



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