

Respecting Choices®

Advance Care Planning Program

Expected Outcomes

Based on our own research¹ and experience helping other organizations implement Respecting Choices, we have identified target outcomes for a comprehensive approach to advance care planning. Some of the outcomes will take a minimum of three years to fully achieve, but improvement can be documented at 1- and 2-year intervals.

Respecting Choices has achieved the following outcomes through organized and managed changes to create an advance care planning system.

Patient Care Outcome Measures

1. Increase the percentage of written advance directives (ADs) at the time of death
 - 75% of decedents will have a written AD at the time of death
 - 96% of the time the AD will be available in the medical record of the healthcare organization caring for the decedent at the time of death
 - 60% of completed ADs will include the appointment of an individual (e.g., healthcare agent, proxy) to make healthcare decisions if the patient no longer has the capacity to do so
2. Reduce the number of hospital deaths by at least 10% of baseline
3. Increase the number of hospice admissions by 10% over baseline (with a minimum mean of 25% of all deaths)
4. Increase the median length of admission to hospice by 10% over baseline (with a minimum mean of 25 days)
5. Increase the transfer of patients' written preferences, found in the AD or provided by the healthcare agent, to appropriate medical orders
 - 90% of the time, patients' instructions are documented by the treating physician and reflected in the physician orders in the organization where the patient died and in out-of-hospital orders at least one week before death

¹ Hammes, Bernard J., Rooney, Brenda L., and Gundrum, Jacob D. (2010). A Comparative, Retrospective, Observational Study of the Prevalence, Availability, and Specificity of Advance Care Plans in a County that Implemented an Advance Care Planning Microsystem, *Journal of the American Geriatrics Society*, 58(7), 1249-1255.

- 100% of the time, physician orders are followed
6. Increase to 90% family members' reports that a physician or other healthcare provider discussed specific plans for the patient's medical care and that these plans were consistent with the medical treatment received
 7. Individuals who participate in an ACP facilitated discussion will rate their satisfaction as a 4-5 on a 5-point satisfaction survey

Process Outcome Measures

1. The organization's written policy and procedure on Advance Care Planning addresses 100% of the following standards:
 - a. Review, entry, and transfer of written ADs
 - ADs are reviewed for accuracy and completeness prior to being entered into the medical record
 - ADs are stored in a consistent place (e.g., in the medical chart)
 - ADs are reviewed upon each admission for update and revision within 24 hours of admission
 - ADs are available at each admission
 - ADs are transferred when a patient moves to a different health care organization or home
 - b. Roles and responsibilities of the ACP Team
 - A qualified team of Advance Care Planning Facilitators is identified
 - ACP facilitators are provided a minimum of 14 hours of ACP training
 - During orientation, all staff (e.g., RNs, social workers, clergy, physicians) receive information on their ACP during orientation
 - A system of referrals for ACP facilitation is established and used by staff
 - All physicians incorporate ADs into treatment orders
2. A community engagement plan is developed that includes the following outcomes
 - 20 presentations scheduled annually to selected community groups
 - 50% of the evaluations of participants include an indication of willingness to follow up and take action to discuss and develop an AD
3. ACP facilitators will report 90% satisfaction with the impact of ACP facilitation on their professional role and responsibility.