Operationalizing Advance Care Planning in Senior Living

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Objectives of this Session

1. Participants will identify basic requirements of advance directives in senior living.

2. Participants will identify key strategies to establish Advance Care Plans with older adults in senior living.

3. Participants will develop 3-5 actionable steps to complete advance care plans with senior living clients or community-dwelling older adults.
Stanford School of Medicine highlights that most people prefer to die at home, but the majority die in acute care hospitals or nursing homes. How do we facilitate choice at the end of life in a nursing home?

- **80%** Prefer to die at home
- **60%** Die in acute care hospital
- **20%** Die in nursing homes
It’s not too late...

Living an assisted living or nursing home center doesn’t mean it is too late to complete an advance care plan!

This process empowers older adults with maintaining autonomy over their lives and their healthcare.

Advance Directives facilitate conversations between older adults, their families, and their care team.

“This experiment of making mortality a medical experience is just decades old. It is young. And the evidence is it is failing.”
— Atul Gawande, Being Mortal: Medicine and What Matters in the End
Regulations Regarding Advance Directives...and beyond...

**Patient Self-Determination Act**

Established in 1990 establishes rights and responsibilities surrounding patients and their advance directives. Requires providers to offer assistance creating advance directive.

**Nursing Home Regulations Regarding Care Plans**

Requires all nursing home residents have a plan of care reviewed and updated quarterly with resident, staff, and family.

**Quality Assurance/Quality Improvement**

Skilled Nursing Facilities are required to hold quality assurance and quality improvement committees which review data and coordinate improvement initiatives.
Definitions

DNR
Order signed by physician which stands for “Do Not Resuscitate.” Limited to CPR. Helpful, but does not address grey area.

Five Wishes
Conversation starting document to clarify end of life wishes.

- Who you want to make health care decisions for you when you can’t make them.
- The kind of medical treatment you want or don’t want.
- How comfortable you want to be.
- How you want people to treat you.
- What you want your loved ones to know.

*Five Wishes is written in easy-to-understand language and is available in several languages.*
Definitions

**POLST/MOLST**
Physician/Medical Orders for Life Sustaining Treatment

**TPOPP**
Transportable Physician Orders for Physician Preferences (Missouri form)
Create Your Own Advance Care Plan Document

With a partner or two, review the advance care plan documents provided to you and circle which components you would add to an advance care plan in your senior living community.
Share with the Group

What were some key elements that your group felt were helpful to creating an Advance Care Plan?
### Who is your Implementation Team, and What are their roles?

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<tbody>
<tr>
<td>Pitcher</td>
<td>Short stop</td>
<td>Second base</td>
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<td>Catcher</td>
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<td>Coach</td>
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With your small group, brainstorm who is your Advance Care Plan team? What would be a good implementation strategy for Advance Care Planning?
Share with the Group

What were your ideas for creating an Advance Care Plan initiative at your Senior Living Community?
Set Specific and Measurable Goals

The team will develop and select an Advance Care Plan for implementation in December 2019.

A timeline for implementation will be set and residents and staff will be trained in April 2020.

One neighborhood will have Advance Care Plans implemented in July 2020.

October 2020 will see two neighborhoods have Advance Care Plans implemented.

Three neighborhoods will have Advance Care Plans implemented in December 2020.
Success from the Field

1. Form a team, including Medical Director, QAPI team.
2. Select a form, at this time TPOPP is recommended by MO/KS Center for Practical Bioethics.
3. Plan implementation: allow time for residents to review and learn about this process.
4. Consider mailing information and a sample to residents, inform physicians.
5. Train your nursing staff about this document and assign point person for questions.
Lessons Learned

1. Consider readiness of your team. Do they have the knowledge and motivation to complete this initiative?
2. Older adults are eager to discuss this topic.
3. This is a vehicle to facilitate conversations about end of life preferences, but grey areas will remain.
4. Set time-limited goals, but allow plenty of time to implement. Ex: ¼ of residents per quarter implement Advance Care Plan.
5. Plan for some staff hesitation with initiative.
6. Remember resident’s right to choose→ The advance care plan is belongs to them, not their family.
Resources for Your Initiative

The links below may be helpful in your pursuit of advance directive implementation.

01 | https://practicalbioethics.org/files/tpopp/Fast-Facts-for-LTC.pdf
02 | https://practicalbioethics.org/files/tpopp/LTC-Implementation-Overview.pdf
03 | https://polst.org/
05 | https://fivewishes.org/five-wishes/health-care-systems
Book Recommendations

- *When Breath Becomes Air* by Paul Kalanithi
- *Being Mortal* by Atul Gawande
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