



Lessons Learned from an Advance Care Planning Intervention for Minority Hospitalized Older Adults

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Project Aim: To ensure low-income and minority elderly hospitalized patients and their health care proxies (HCP) are fully informed about their ability to make future treatment decisions.

Background

- Aggressive end-of-life care is the default in American hospitals unless limits are set, but not everyone wants this approach
- Discussion about preferences with primary care provider (PCP) before hospitalization or medical crisis is ideal
- Racial /ethnic minority and impoverished patients often lack consistent PCP and opportunities to understand and engage in ACP
- Routine in-hospital inquiries about ACP are frequently cursory especially in this “hard-to-reach” group
- A hospital stay represents a window of opportunity for more robust discussion
- Likelihood of future care consistent with preferences is increased when wishes are documented

Methods

- Phase 1: Preparation:** Two facilitated focus groups with patients and/or family caregivers from minority communities (Total N = 21) sought recommendations for best practices; responses thematically analyzed
- Phase 2: Active Intervention:** Two project-dedicated trained social workers approached eligible patients about 3 days prior to hospital discharge to engage in ACP conversations
- Patient eligibility for intervention: Hospitalized patients ages > 65 being discharged home, no previous palliative care referral, members of racial/ethnic minority or Medicaid-eligible, and prior approval of treating team
- For this study, ACP documents included: Health Care Proxy, Living Will, or Medical Orders for Life Sustaining Therapy forms
- Follow-up included ensuring next-of-kin knew of patients’ wishes; patients were given a copy of all completed ACP documents; and copies were uploaded into electronic health record and sent to PCP (if identified)

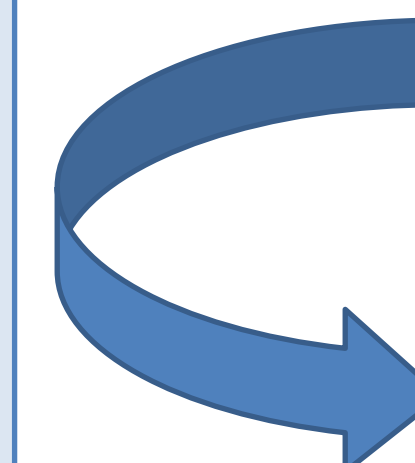
Stakeholder Recommendations for Engaging in Advance Care Planning (ACP) Conversations

- **Approaches**
 - Build rapport/relationship before launching into this sensitive topic
 - Acknowledge difficulty of hospitalization and other life challenges
 - Frame ACP as empowerment and a gift for patient’s family rather than hospital requirement or obligation
- **Cultural and Religious Considerations**
 - Context of faith-based values and spirituality
 - Family values and dynamics – learn from patient which family or community members should be present
 - Help patients understand “You own this document”
- **Language is crucial**
 - Show concern/respect for patient as a person
 - Personalize the conversation, use titles like Mr., Mrs.
 - Emphasize flexibility: ability to change your mind
 - Literacy: don’t assume people can read and write
 - Provide ACP counseling in patient’s primary language
- **Timing**
 - No expectation for immediate decision
 - Allow patient to choose site, time and pace of discussion
 - Be willing to revisit the topic as needed
 - Provide follow-up contact info in case of questions that arise
- **Turn-offs**
 - Too much information delivered too fast
 - Condescending or hurried tone
 - Lack of choices
 - Not listening to patient or family concerns
 - Pressure to make a decision or sign name without fully understanding ramifications of ACP

Findings

Phase 1: See center panel
Phase 2: Ongoing intervention provided to **823** hospitalized patients to date

| | Total N | % | |
|--|----------------------|--------|--------|
| Gender | Female | 439 | 53.4 % |
| | Male | 384 | 46.6 % |
| Race | Black | 475 | 57.7 % |
| | White | 315 | 38.3 % |
| | Other | 33 | 4.0 % |
| Ethnicity | Hispanic or Latino/a | 52 | 6.3 % |
| Status of ACP at First Contact | | | |
| No current ACP documents | | | |
| Outdated documents required changes or discussion | 81 | 9.8 % | |
| Current ACP document, no intervention needed | 257 | 31.2 % | |
| Declined any discussion | 25 | 3.0 % | |
| Follow-up outcomes for those with no current ACP document | | | |
| A new ACP was completed | 399 | 86.7 % | |
| Patient still contemplating ACP specifics | 23 | 5.0 % | |
| Patient did not complete, no follow-up requested | 38 | 8.3 % | |



Conclusions

The majority of high-risk, vulnerable hospitalized patients did not have any future care documents at initial contact. A dedicated and sensitive approach to ACP discussions among at-risk hospitalized patients who have not previously completed any future directives is both feasible and achievable in hard-to-reach populations.

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